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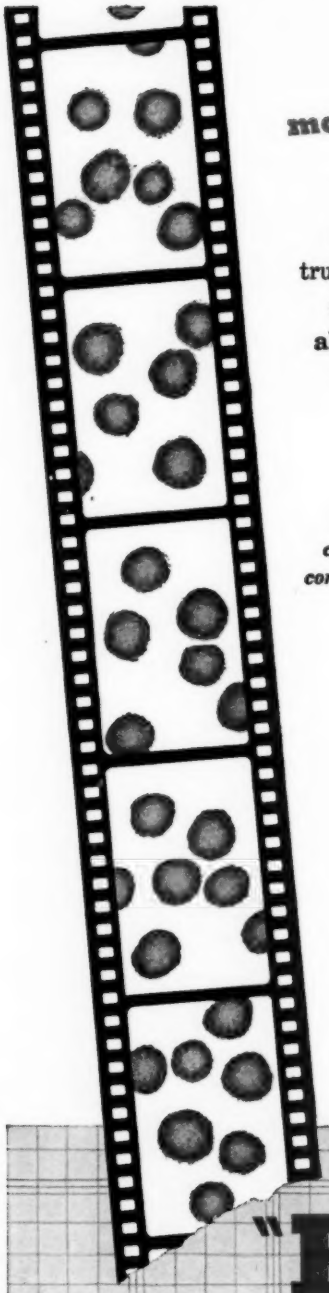

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Tampax, Incorporated
Upjohn Company
Warner-Hudnut, Inc. (Medical Prod. Div.)
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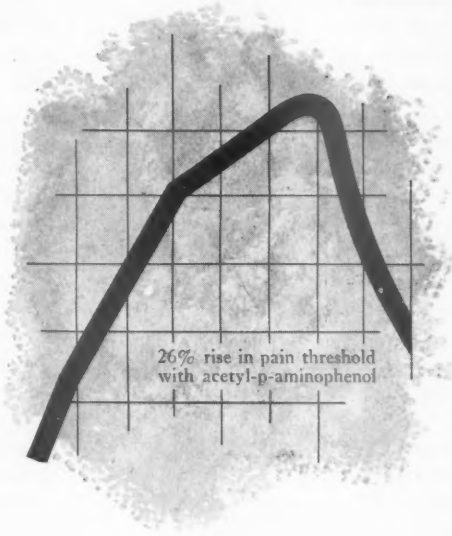
new, fast-acting analgesic

containing acetyl-p-aminophenol



Because of its content of acetyl-p-aminophenol, Trigesic quickly raises the pain threshold and provides rapid, sustained relief of pain. A definite rise in pain threshold occurs within 30 minutes and analgesia is maintained for about 4 hours. Trigesic is for relief of pain in common colds, grippe, dysmenorrhea, premenstrual tension, sciatica, simple headache, after dental extractions and minor surgery, rheumatism, migraine, sinusitis, bursitis, myositis and pains of neuropathic origin.

Trigesic, ***per tablet:***

0.125 Gm. (2 gr.) acetyl-p-aminophenol, 0.23 Gm. (3½ gr.) aspirin, 0.03 Gm. (½ gr.) caffeine. Bottles of 100 and 1,000 white, scored tablets on prescription only.

Trigesic with Codeine, ***per tablet:***

16 mg. (¼ gr.) or 32 mg. (½ gr.) codeine phosphate in addition to the other ingredients. Bottles of 100 and 1,000 pink, scored tablets on prescription only.

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Squibb Analgesic Compound

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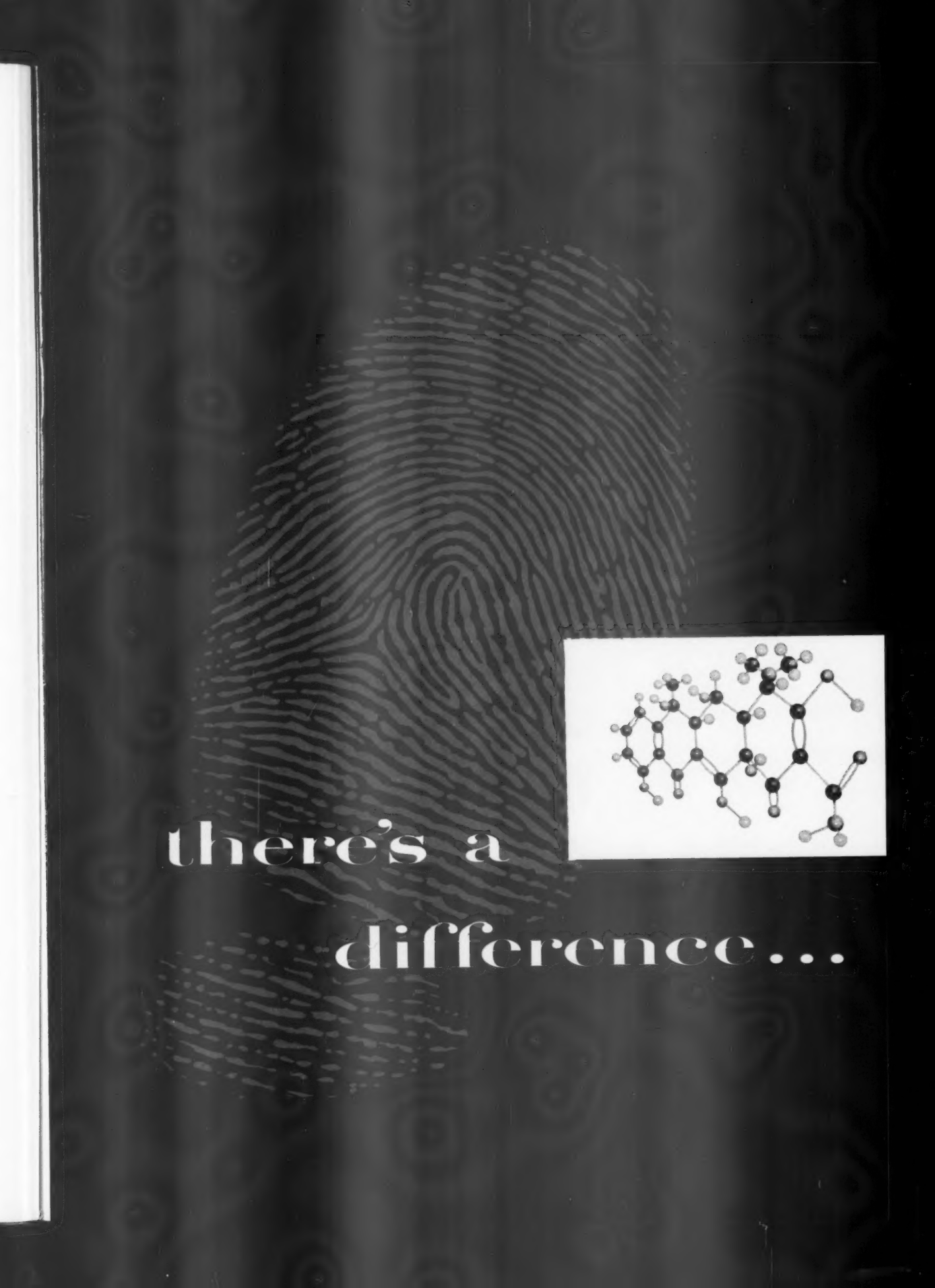
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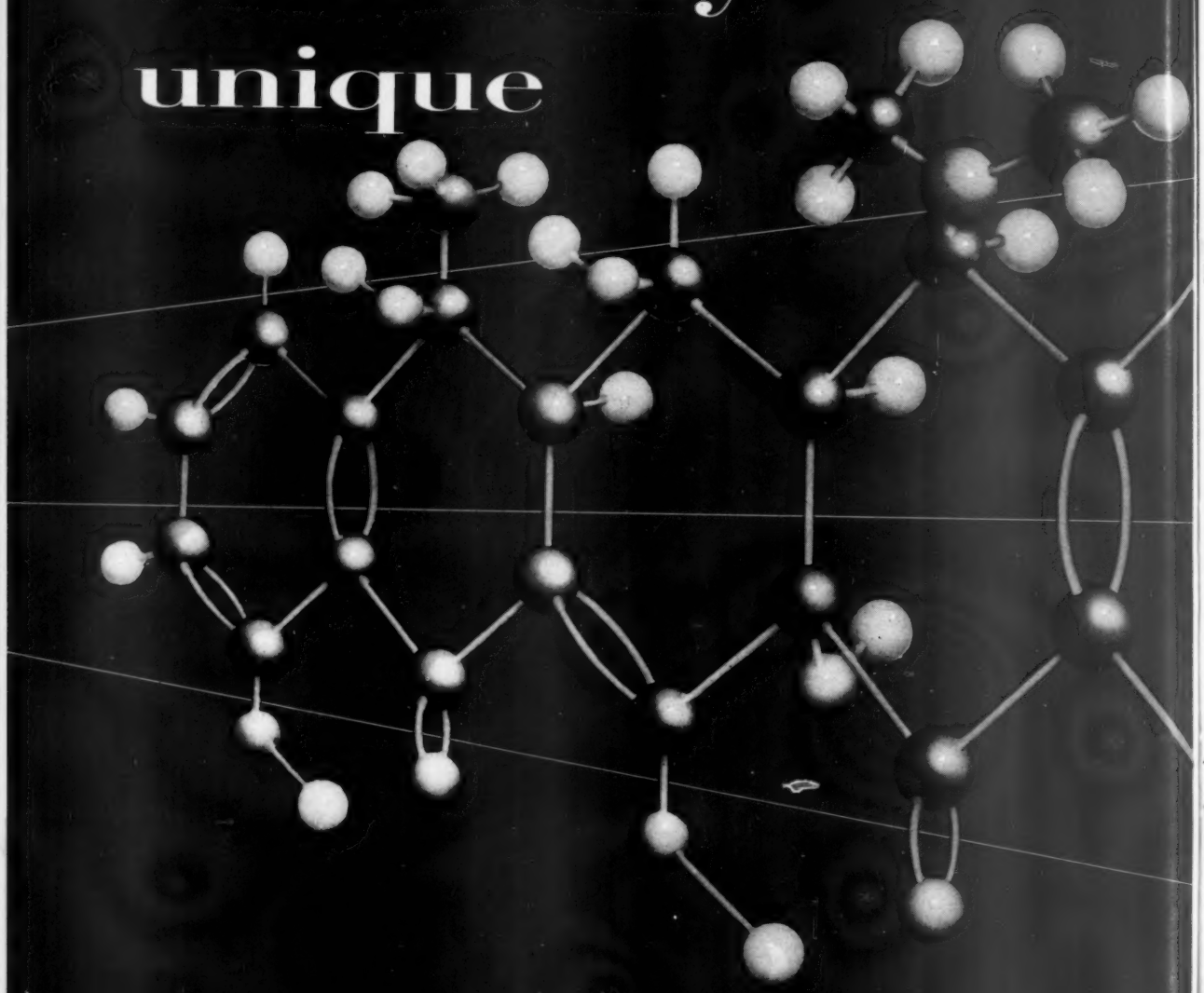
chemically unique



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of its
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clinically unexcelled

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for TOLERATION

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For the patient under tension

Trasentine®-Phenobarbital

(*brand of adiphenine*)

relief of smooth-muscle spasm, easing of pain

Worry, anxiety, fear—such "pressures" often account for visceral spasticity. To offset them, Trasentine-Phenobarbital provides mild sedation—as well as effective spasmolysis, rapid relief of pain.

Whenever you suspect a psychosomatic factor in visceral spasm, Trasentine-Phenobarbital is a logical prescription. Each tablet contains 50 mg. Trasentine hydrochloride and 20 mg. phenobarbital. Bottles of 100 and 500. *Ciba Pharmaceutical Products, Inc., Summit, New Jersey.*

Ciba

On every count.. superior vitamin supplements for infants

acceptability

The superior flavor of all three "Vi-Sols" assures patient acceptance. Mothers appreciate their convenience too.

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With their clear, non-sticky texture, the "Vi-Sols" disperse instantly in fruit juice or water, mix readily with formula.

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Since all their vitamins are in synthetic form, the "Vi-Sols" are well tolerated even by allergic patients.

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Stable at room temperature, the "Vi-Sols" require no refrigeration. They may safely be autoclaved with the formula.

the versatile "Vi-Sols"

3 water-soluble vitamin preparations for drop dosage

POLY-VI-SOL
TRI-VI-SOL
CE-VI-SOL

Available in 15 and 50 cc. bottles, with calibrated droppers

	Vitamin A	Vitamin D	Ascorbic Acid	Thiamine	Riboflavin	Niacinamide
POLY-VI-SOL Each 0.6 cc. supplies	5000 Units	1000 Units	50 mg.	1 mg.	0.8 mg.	5 mg.
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Specific

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VAGINITIS

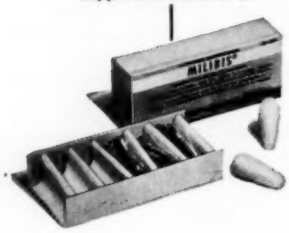
Milibis®

VAGINAL SUPPOSITORIES

Highly Effective · Well Tolerated

Average Dose: One suppository inserted every other night, before retiring, for five doses. An acid douche should be used on the alternating nights. In some cases, it may be necessary to extend or repeat the course.

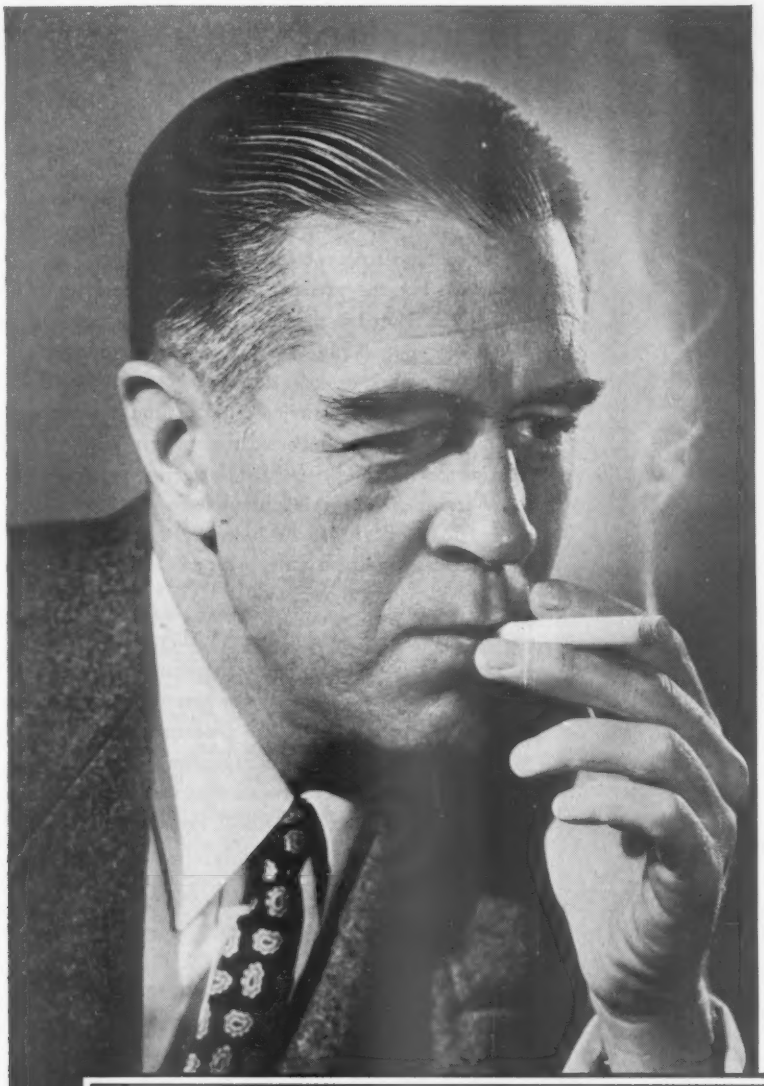
Supplied in boxes of 5.



WINTHROP-STEARNS INC.

NEW YORK 18, N. Y., WINDSOR, ONT.

Milibis, trademark reg. U. S. & Canada, brand of bismuth glycolylarsanilate



Doctor, be your own judge... try this simple test

With so many claims made in cigarette advertising, you, Doctor, no doubt prefer to judge for yourself. So won't you make this simple test?

Take a PHILIP MORRIS and <u>any</u> other cigarette

1. Light up either one first. Take a puff—get a good mouthful of smoke —and s-l-o-w-l-y let the smoke come *directly* through your nose.
2. Now, do exactly the same thing with the other cigarette.

Notice that PHILIP MORRIS is definitely less irritating, definitely milder.

PHILIP MORRIS

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Conception Control
without a diaphragm

a **GEL** with applicator
for simple, dependable contraception

Preceptin®
VAGINAL GEL

with measured-dose applicator

PRECEPTIN vaginal gel contains the active spermicidal agents p-Diisobutylphenoxy-polyethoxyethanol and ricinoleic acid in a synthetic base buffered at pH 4.5.

Ortho

Ortho Pharmaceutical Corporation
Raritan, New Jersey

Scientific News Notes

ELI LILLY announces that *INH* (Isoniazid, Lilly) is one of the most recent of the promising new anti-TB drugs which have been released for treatment of selected tuberculous cases under close medical supervision. For the present, the recommended use of *INH* is limited to the treatment of TB victims who are not responding satisfactorily to streptomycin therapy. There is some concern about the possible effects of its indiscriminate use inasmuch as some investigators have reported the emergence of resistant strains of tubercle bacilli after varying periods of treatment with this substance. For this reason, it is felt that *INH* should be reserved for use in selected cases in which it may serve as a life-prolonging or even lifesaving measure.

Following its debut at the A.M.A. Convention, *Carbo-Resin* (Sodium Removing Resins, Lilly) Unflavored, has been placed on the prescription market. *Carbo-Resin* is blended into foodstuffs which hold and disguise this new medication for the removal of excess sodium from the bodies of patients who suffer from heart disease, cirrhosis of the liver, edema of pregnancy, or hypertension.

* * * *

WINTHROP-STEARNS, INC. is supplying *primaquine* in tablets of 26.5 mg. (15 mg. base) for treatment of malaria. This product was reported on in the *Journal of the A.M.A.* recently as a new antimalarial which destroys the parasite causing relapsing malaria. Production of this compound is being diverted largely into military channels, but most civilian demands are expected to be met.

Pipanol hydrochloride, a potent antispasmodic in elixir form, has been made available to the medical profession by WINTHROP-STEARNS, INC. Used in the treatment of Parkinson's disease, this product has heretofore been available only in tablet form.

* * * *

ABBOTT LABORATORIES announces that *Isolyn* (Isoniazid, Abbott is recommended as an adjunct

From Our Advertisers

to treatment of streptomycin-resistant tuberculosis or of tuberculosis not responding to previous therapy. Primarily employed to date where prolonged medical and surgical treatment have failed to check the downhill course of chronic or far-advanced cases, good results have been reported in miliary and meningeal tuberculosis; tuberculosis of bone and joint are also favorably affected. *Isolyn* offers the possibility of preserving life where prognosis heretofore has been poor.

* * * *

MERCK & CO., INC. announces a 40 percent reduction in the price of *Cortone,* the Merck brand of cortisone, due to savings in manufacturing costs. *Hydrocortone,* the Merck brand of hydrocortisone acetate, has also been reduced in price. This product is injected directly into the joints of patients suffering from rheumatoid or osteoarthritis. *Hydrocortone* is also available in tablet form. Other therapeutic potentialities of this product are being explored.

MERCK & CO., INC. also announces the availability of the emulsion of *Mephyton,* the Merck brand of vitamin K_1, which has a dramatic effect in stopping hemorrhages induced by derivatives of coumarin and where actual or potential bleeding is threatened from certain other causes, including vitamin K deficiency. Administered intravenously, *Mephyton* begins to act within minutes and controls bleeding promptly.

* * * *

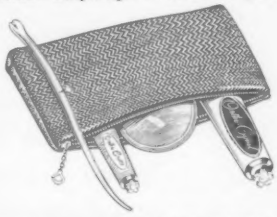
PARKE, DAVIS & COMPANY, on the basis of a decision by the Food and Drug Administration, announces, "Physicians may continue to prescribe *Chloromycetin* for treatment of any disease as they see fit, but are cautioned against using the antibiotic indiscriminately or for minor infections. The studies show that blood disorders may be associated with intermittent or prolonged use not only of this antibiotic, but a number of other drugs, in which case adequate blood studies should be made."

Conception Control *with* a diaphragm

TWO COMPLETE UNITS
in attractive plastic zipper kits
durable • washable

Ortho Kit®

contents: Ortho-Gynol® vaginal jelly (regular size tube)
Ortho® Creme vaginal cream (trial size tube)
Ortho® Diaphragm (coil spring) } 55 mm. to
Ortho® Diaphragm Introducer } 95 mm.



Ortho® White Kit

contents: Ortho-Gynol vaginal jelly (regular size tube)
Ortho Creme vaginal cream (trial size tube)
Ortho®-White Diaphragm (flat spring)
55 mm. to 95 mm.

with the most widely prescribed vaginal jelly and cream

Ortho-Gynol vaginal jelly—ricinoleic acid 0.75%, boric acid 3.0%, oxyquinoline sulphate 0.025%, p-Diisobutylphenoxypolyethoxyethanol 1.00%.

Ortho Creme vaginal cream—ricinoleic acid 0.75%, boric acid 2.0%, sodium lauryl sulphate 0.28%.

Ortho

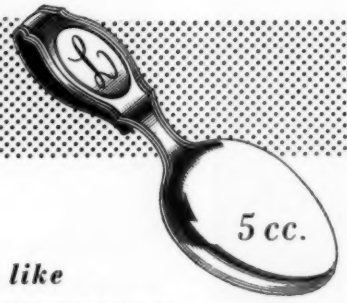
Ortho Pharmaceutical Corporation
Raritan, New Jersey

Easy-to-Take Antibacterial for Infections in Children

When hypos frighten and tablets stick in reluctant throats, both child and parent welcome palatable Suspension 'Neopenzine.' In it the three "ideal" sulfonamides are combined with penicillin—G to provide broad-spectrum antibacterial action. The usual twenty-four-hour dose (one teaspoonful four times a day) provides 800,000 units of penicillin—G and 2 Gm. of the "diazine" sulfonamides. If the urinary output is normal, no alkalies are necessary. Prescribe the 60-cc. potency-protector combination package—at pharmacies everywhere.

Eli Lilly and Company
Indianapolis 6, Indiana, U.S.A.

Lilly



children like
SUSPENSION

(approximately one teaspoonful) contain:
Penicillin—G, Crystalline-Potassium (Buffered).....200,000 units
"Diazine" Sulfonamides.....0.5 Gm.
(Sulfa: Diazine-Merazine-Methazine, of each, 0.167 Gm.)

Neopenzine

(PENICILLIN WITH SULFONAMIDES, LILLY)

Journal of the
AMERICAN MEDICAL WOMEN'S ASSOCIATION

VOLUME 7 OCTOBER 1952 NUMBER 10

UNITED NATIONS—PAN AMERICAN NUMBER

SEVEN YEARS AGO, on October 24, 1945, the charter of the United Nations came into force and this day, now known as United Nations Day, is celebrated annually throughout the world. The day has a special significance this year as all peoples threatened by war look to the United Nations as the hope of the world, realizing that only by co-operation of free nations can there be freedom or security.

It is true the high hopes entertained in San Francisco in 1945 have not all come to fruition, but the United Nations and, more particularly, its specialized agencies, in spite of unforeseen and dangerous obstacles, have eloquently demonstrated that it is possible for the nations of all the world both large and small to live and work together in mutual co-operation, assistance, and trust.

Of the several specalized agencies which are affiliated with the United Nations, the World Health Organization has been outstanding in its accomplishments. The JOURNAL has published each year a special WHO number summarizing the year's activities of this important agency. In this October number we are privileged to present the Fiftieth Anniversary Report of the Pan American Sanitary Bureau, which was selected by WHO to be Regional Office for the Western Hemisphere. The PASB, oldest of the international health secretariats, was created by the Second International Conference of American States, held in Mexico City in 1901-1902, and formally organized by the first Pan American Sanitary Conference in Washington in December of 1902. It is now celebrating its fiftieth year of endeavor to improve the health of the Americas.

Carrying on the theme Pan American Health, we are publishing in this Pan American number articles of and by our colleagues in the Western Hemisphere, our "Good Neighbors" of North and South America. Backgrounds, customs, and philosophies may differ but aims and purposes are the same: the promotion of health and the prevention of disease. This JOURNAL goes to the women physicians of these two great continents, carrying with it a message of good will and a desire for closer co-operation among the medical women of the Americas.

ADA CHREE REID, M.D.

LAS NACIONES UNIDAS—NUMERO PAN AMERICANO

SIETE ANOS ATRAS, el 24 de octubre de 1945, entraron en efecto las regulaciones de las Naciones Unidas. Aquel día quedó marcado como el día de las Naciones Unidas, y se celebra anualmente como tal por todo el mundo. Este año tiene un significado particular, ya que todos los pueblos amenazados por la guerra, vuelven sus ojos a las Naciones Unidas considerándolas la esperanza de mundo y comprendiendo que solamente mediante la cooperación de las naciones libres puede existir la libertad o la seguridad.

Verdad es que no todas las grandes esperanzas que se avivaron en San Francisco en 1945 han dado su fruto pero las Naciones Unidas y muy particularmente sus agencias especializadas, a pesar de obstáculos peligrosos e imprevistos que han encontrado en el camino, han demonstrado elocuentemente que el hecho de que todas las naciones del mundo, —grandes y pequeñas—, vivan y trabajen juntas cooperando mutuamente ayudándose y confiando la una en la otra, es una posibilidad factible.

Entre las varias agencias especializadas afiliadas a las Naciones Unidas, la Organizacion Mundial de Sanidad sobresale por su notable obra. El JOURNAL OF THE AMERICAN MEDICAL WOMEN'S ASSOCIATION ha publicado cada año un número especial dedicado a la OMS, con un resumen de las actividades anuales de esta importante agencia. En este número de octubre tenemos el honor de presentar el Informe del Cincuentenario de

la Oficina Sanitaria Panamericana, que fué seleccionada por la OMS como su Oficina Regional para el Hemisferio Occidental. La OSP, que es el secretariado mas antiguo dedicado a la salud internacional, fué creada por la segunda Conferencia Internacional de los Estados Americanos, que tuvo lugar en la ciudad de México, 1901, 1902, y que organizó oficialmente la primera Conferencia Sanitaria Panamericana en Washington, el mes de diciembre de 1902. La Oficina esta ahora celebrando su cincuentenario de trabajo para mejorar la salud de las Américas.

Sobre el tema—Salud Panamericana—pulicamos en este número Panamericano, artículos sobre nuestras colegas del Hemisferio Occidental, y artículos escritos por ellas, nuestros "Buenos Vecinos" de la América del Norte y la América del Sur. Los antecedentes, costumbres y filosofías de cada uno pueden ser distintas, pero las finalidades y los propósitos son los mismos.: la mejora de la salud y la prevención de la enfermedad. Este JOURNAL OF THE AMERICAN MEDICAL WOMEN'S ASSOCIATION va a las mujeres médicas de estos dos grandes continentes, llevando con él un mensaje de buena voluntad y el deseo de una colaboración mas estrecha entre las mujeres de las Americas que trabajan en medicina.

WHO and PASB in the Americas

SINCE 1949, the Pan American Sanitary Bureau has functioned as the Regional Office for the Americas of the World Health Organization (WHO). The director of the Bureau is also regional director of the World Health Organization. WHO, with headquarters in Geneva, Switzerland, has set up six regional offices, each one representing a major geographical area of the world. In areas where international health operations and organizations were already in existence, such as the Pan American Sanitary Bureau in the Americas, agreements were worked out whereby all public health efforts could be co-ordinated under centralized authority.

The Pan American Sanitary Bureau, the first international health agency to be established, has been in operation since 1902. The Bureau is the executive organ of the Pan American Sanitary Organization. That organization was created in 1947 by the Thirteenth Pan American Sanitary Conference and consists of four component parts: the Conference, (the supreme governing body); the Directing Council (consisting of representatives of each Member Government); the Executive Committee (composed of representatives of seven Member Governments chosen on a revolving basis); and the Pan American Sanitary Bureau, which executes the programs under a Director chosen by the Conference.

At the Thirteenth Pan American Sanitary Conference in Ciudad Trujillo in 1950 it was decided that the fiftieth anniversary of the Bureau should be celebrated. On the invitation of the Cuban Government—wishing at the same time to honor Dr. Carlos Finlay for his great contribution on the transmission of yellow fever—this celebration was to be held in Havana under joint sponsorship of that Government and the Pan American Sanitary Organization. This event marks the first 50 years of continuous service by an international health organization.

HEALTH PROBLEMS IN THE AMERICAS

Definite information on epidemic diseases in the Americas before 1492 is lacking, but it is known that the contact between what was called the "old" and the "new" worlds produced outbreaks of considerable importance among the natives of the Americas and later on in native Europeans. The spread of smallpox, measles, tuberculosis, and diphtheria is mentioned by the earliest writers. Later on the descriptions of yellow fever all over the world, and of syphilis, and, in more recent times, epidemic plague and cholera, indicate the results of the interchange between Europe and the Americas—and in some cases, particularly plague and cholera, from Asia to Europe and the Americas. Of the diseases briefly mentioned, cholera never established itself in the Americas, but all of the others did, not counting diseases such as verruca peruviana or bartonellosis, which are truly American.

During the eighteenth and nineteenth centuries, the increase in commerce and the opening of ports in the new nations contributed both to the cultural and economic interchange and to the more rapid spread of epidemic diseases from country to country.

More than any other region of the world, the nations of the Americas found themselves with very serious problems of international health beset by epidemic diseases, particularly yellow fever, which interfered seriously with their economic, social, and political development. To help each other, the nations began a series of regional meetings, held between 1870 and 1900, to agree upon quarantine measures and to establish an international system of disease reporting.

It was at a meeting in 1881, held in Washington and called by United States, that Dr. Carlos Finlay, a Cuban scientist attending as the representative of Spain, first announced his theory of the transmission of yellow fever by mosquito (identified later as *Aëdes aegypti*). At the First and Second International Conferences of the American States in 1889-1890 (Washington) and 1901-1902 (Mexico City), efforts were made toward establishing international sanitary regulations. At Mexico City, the Committee on International Sanitary Policy submitted a draft proposal recommending the calling of a sanitary conference of all the American republics, and the creation of a permanent "International Sanitary Bureau."

On January 28, 1902, this draft proposal won unanimous approval by all delegations present. Thus the "International Sanitary Bureau," as it was first called, was born. Its office was in Washington.

A set of resolutions were also passed at that time outlining the duties of the newly formed Bureau and providing a source of funds for its operations. Each republic was to transmit promptly and regularly to the Bureau all data of every character relative to the sanitary conditions of its ports and territories. The Bureau was to "encourage and aid or enforce in all

proper ways the sanitation of seaports, including the sanitary improvement of harbors, sewerage, drainage of soil, paving, elimination of infection from buildings, and the destruction of mosquitoes and other vermin."

From these modest beginnings in 1902, the Bureau has had steady, gradual growth. International Sanitary Conferences were held periodically, making revisions in the sanitary "conventions" and expanding the activities of the Bureau. In 1924, it was decided that the International Sanitary Conferences should henceforth be called Pan American Sanitary Conferences and the Bureau was given its present name, Pan American Sanitary Bureau. During this meeting, held in Havana, the Pan American Sanitary Code was approved, broadening the scope of the Bureau to include public health assistance in the control of epidemic and endemic diseases within individual countries. This wider concept was considered more practical than merely the control of disease in port cities, and has laid the groundwork for the present continent-wide programs being carried on throughout the Americas.

PUBLIC HEALTH PROGRAMS IN THE AMERICAS

Science has contributed in recent years the knowledge and equipment necessary to rid the world of many of its most widely spread communicable diseases. The application of this knowledge is now a question of economics and administration. Modern insecticides such as DDT can exterminate malaria- and yellow fever-carrying mosquitoes, typhus-carrying lice, as well as flies and other insect vectors. Antibiotic drugs are the modern weapon against venereal disease. Effective immunization by vaccination has been developed for control of several diseases: smallpox, diphtheria, typhoid, typhus, cholera, and whooping cough.

PASB and WHO in the Americas, as elsewhere, offer advisory and technical services to all countries in the region. Upon the request of governments, expert consultants and demonstration teams are provided to give practical help in the solution of their health problems. A WHO demonstration team works side by side with local people, collaborating with the public health authorities in the country. As local technicians are trained, they replace the international personnel, thus assuring the continuation of the health program.

The serious shortage of trained health workers presents one of the most challenging problems in the region of the Americas today. This challenge is being met in a variety of ways. Individual fellowships are granted to doctors, nurses, engineers, veterinarians, and other public health workers for special study outside their own countries. Assistance is given to medical institutions to enable them to expand their training facilities. Various types of seminars, conferences, and group-training schemes are sponsored by PASB/WHO and co-operating organizations in the Americas. Training activities are an integral part of most of the special public health projects now in progress in this region.

PUBLIC HEALTH ADMINISTRATION

The concept of a health demonstration area was first formulated at the Second World Health Assembly and further developed at the Third Assembly, held in May 1950. In contrast to specialized programs against specific diseases, the health demonstration area was to be a program of comprehensive health services. The services include the following: public health administration; environmental sanitation; vital statistics; communicable disease control; administration of hospitals; medical and dental care; health education; promotion of health through maternal and child health services, nutrition, mental health, and occupational health activities; and laboratory services.

Requests for such a health demonstration area were received from seven countries of the Americas. After a comprehensive survey, a section was selected in the valley of San Andrés in El Salvador, which has a population of 167,000 and is some 1,200 square kilometers in area. The area is rural and underdeveloped. The health problems of the area include malaria, tuberculosis, bacillary and amoebic dysentery, syphilis, malnutrition, intestinal parasite infestation, general respiratory illness, and high infant mortality.

Worker employed under PASB/WHO/UNICEF Insect Control Program is stencilling letters "DDT" on door in Guatemala.

The Government of El Salvador took an active part in launching the project, including training of personnel, selection of the sites for health centers and clinics, and local publicity. Plans were developed, under which WHO, with Technical Assistance funds, started in May 1951 to provide experts, supplies, equipment, and fellowships. By the end of the year, a chief medical officer, a sanitary engineer, and a public health nurse had started work. The aim of the program was to improve not only the conditions of public health, but also of agriculture, industry, and education. It was expected to continue for five years, and have the active participation of a number of international organizations, including FAO, ILO, and UNESCO.

The health demonstration area in El Salvador was planned as a proving ground and model for the development of techniques and methods which could be adapted to other countries of the Hemisphere.

MATERNAL AND CHILD HEALTH

During 1951, the activities of the Pan American Sanitary Bureau in promoting maternal and child health were expanded and strengthened. Programs were under way in many countries. Close co-operation was continued with the United Nations International Children's Emergency Fund (UNICEF). The countries carrying on activities in maternal and child health with the co-operation of the Bureau are Brazil, Chile, Colombia, Ecuador, El Salvador, Paraguay, and Peru.

NURSING

During 1951 as in previous years, both consultation and services were given to various governments in Latin America in the reorganization of public health nursing services; in the in-service staff education of nurses; and in studies of nursing schools. The Nursing Section of the Bureau also assisted in both school and field plans for nursing-fellowship students who were studying in the United States. Co-operation with students of nursing under fellowships was carried on at headquarters in Washington, and advice given them about their studies.

Costa Rica

The nursing education consultant, PASB, completed a report on the survey of the School of Nursing. The way was cleared for putting the recommendations of this study into operation, when the Government of Costa Rica signed the agreement for the project (TA/WHO) on May 25, 1951, and a team of four international nurses began the project in July.

A study was made of the public health nursing program in Costa Rica where plans were completed for in-service staff education of nurses and *visitadoras* in the Ministry of Public Health.

Nursing programs are also being carried on with the assistance of the Bureau in Ecuador, Guatemala, Mexico, and Peru.

COMMUNICABLE DISEASES

The communicable diseases branch of the Division of Public Health administered a large number of programs during the year, including those against yellow fever, diphtheria and whooping cough, hookworm, typhus, malaria, onchocerciasis, schistosomiasis, the treponematoses, tuberculosis, smallpox, influenza, poliomyelitis, and plague; and also against zoonoses such as brucellosis, foot-and-mouth disease, hydatidosis, and rabies.

YELLOW FEVER

Cases of jungle yellow fever occurred in Panama in each of the four years 1948, 1949, 1950, and 1951, where the disease had not been diagnosed for several decades. The extensive outbreaks in Bolivia (1950), and on the Pacific slope of Ecuador (1951), and in Costa Rica (1951), were all in areas not previously incriminated. These outbreaks, plus the finding of immune monkeys in southeastern Mexico, led to the conclusion that jungle yellow fever is, from time to time, present in all the countries on the mainland of the Americas, except the United States and Canada in North America, and Uruguay and Chile in South America.

Although endemic urban yellow fever has disappeared from the Americas as a result of anti-*aegypti* measures, jungle yellow fever persists as an important threat to rural populations and as a potential source of infection to urban areas where *aegypti* has not been eradicated. It is therefore essential to continue studies on the epidemiology of jungle yellow fever and on methods of production and application of yellow fever vaccine, and to emphasize the importance of the complete eradication of the *Aedes aegypti* mosquito from the Americas.

TUBERCULOSIS

During 1951, WHO, with the assistance of UNICEF, took over the work in BCG vaccination campaigns previously done by the Joint Enterprise of Copenhagen, Denmark. These campaigns were undertaken only in countries where collateral facilities for tuberculosis control were available.

In connection with the BCG campaigns planned for the Americas by WHO/UNICEF, the Regional Office assisted in placement of teams (each consisting of a doctor and two nurses) from Costa Rica, El Salvador, Peru, and Jamaica, for training in organization and planning of mass campaigns. The training was carried out in Ecuador, where a mass BCG project under the auspices of the Joint Enterprise had been in operation.

Physician applying first anti-yellow fever vaccine (Dakar type) to citizen of Puerto Viejo, Costa Rico, to initiate work and training of personnel.

The development of new drugs has given future promise of additional weapons in combating the scourge of tuberculosis. The new compounds are technically described as isomers of niacin, the anti-pellagra vitamin. In 1951, the use of the new drugs was still in the experimental stage, and it was evident that much more work would be required to determine their place in the treatment of tuberculosis.

Ecuador

The BCG vaccination campaign, begun in July 1950 by the Government and the Joint Enterprise of Copenhagen, assisted by the regional adviser in tuberculosis, was completed in July 1951. During the campaign, 640,000 persons in the age group of 1 to 30 years were examined and about 350,000 of them were vaccinated. In the course of their year's work, the vaccinating teams that traveled about the country started an intensive anti-tuberculosis educational program. Work carried out with the radiographic mass survey centers led to the discovery and treatment of many incipient cases of tuberculosis.

The Tuberculosis Control and Teaching Center (WHO/TA/UNICEF) began operating in September, when the bacteriologist recruited for the project arrived in Ecuador. The Government of Ecuador offered 25 fellowship years for persons from other Latin-American countries, in the field of tuberculosis.

El Salvador

The Tuberculosis Control Demonstration Project (WHO) completed its work in San Miguel in February 1951 and in San Vicente in September 1951. During seven months' activity in San Miguel, some 15,000 persons, out of a population of 22,000, were examined. Suspicious shadows in 574 persons were found by radiographic examination; 512 of these were examined bacteriologically, utilizing sputum or gastric lavage specimens, and about two-thirds were found positive. More than 4,000 persons in San Miguel received BCG vaccinations from the team. In both San Miguel and San Vicente, physicians and nurses connected with the Department of Health were trained in modern

techniques of tuberculosis control. The Salvadorean authorities asked to have the program continued through 1952.

A mass BCG program (WHO/UNICEF) began in September. During the first week, 35,000 persons were tested and 18,000 were vaccinated, mostly children of school age.

Jamaica

A mass BCG vaccination campaign (WHO/UNICEF) was started in September 1951. UNICEF furnished $106,000 worth of supplies and equipment. WHO provided training in Ecuador for a doctor and two nurses, and sent an inter-country BCG adviser for one month to help organize and initiate the program. Under the Tuberculosis Control Program (WHO/UNICEF) a tuberculosis survey by means of radiographic and bacteriologic investigations was begun.

Paraguay

Detailed plans were made for helping with an improved program (TA/UNICEF) in tuberculosis control and a rural demonstration scheme to combat the disease. The project was designed to amplify the work in tuberculosis control in Asuncion, and extend it into a number of the larger rural communities. Personnel and fellowships were to be provided. The program is to last for two years, beginning in 1952.

Peru

Plans were made to set up a demonstration program (WHO/UNICEF) in tuberculosis control starting in 1952 in connection with the maternal and child health program for the Lima-Pativilca area.

Trinidad

A team from Trinidad has been trained in Jamaica, with a view to starting the BCG vaccination campaign in 1952, under the auspicies of WHO and UNICEF.

TREPONEMATOSES

Not much data is available about the incidence and prevalence of the venereal diseases and the other treponematoses in the Americas; but findings in serologic surveys of selected groups have shown that the need to combat these diseases is of prime importance. For this reason, the Pan American Sanitary Bureau created, early in 1950, a section of venereal disease within the Division of Public Health. The work of this section obviously had to be enlarged to include the other treponematoses.

During 1951, the training of personnel in the standard techniques for the serodiagnosis of syphilis was intensified. The ground was prepared for carrying out experimental projects in the control of venereal diseases. Personal consultations were had by the professional staff of the section with the appropriate officials in the Americas, in order to gather all available data concerning the administration and operation of control programs.

Demonstration and training projects against venereal infections were begun in collaboration with the Government of Ecuador, and plans were made for a similar program in Paraguay, beginning during 1952.

Antigens

Steps were taken by WHO towards establishing the control and standardization of cardiolipin and lecithin antigens throughout the world. With the collaboration of WHO, a monograph on production and control methods was prepared by the Division of Laboratories and Research of the New York State Department of Health, which acted as a WHO Center for standardization and control of cardiolipin and lecithin antigens.

Penicillin Testing

During the year, numerous lots and samples of penicillin (representing supplies from various parts of the world) were received from WHO in Geneva for testing.

Puppy being vaccinated against rabies in El Paso, Texas, while 7-year-old owner watches camera. The doctor is member of staff of WHO Regional Office for the Americas.

VETERINARY PUBLIC HEALTH

The Veterinary Public Health Section of PASB is concerned with the prevention, control, and eradication of animal diseases transmissible to man (zoonoses), as well as the prevention of human diseases caused by unsafe foods derived from animals. The section provides a center of information about the incidence, prevalence, and control of zoonoses throughout the Americas and evaluates, publishes, and distributes such information.

Campaigns to control brucellosis, foot-and-mouth disease, hydatid disease, and rabies are among the field programs which have been developed and supervised by the Veterinary Public Health Section, and attention is also being given to meat hygiene. A number of very favorable comments were received regarding the work of this section and there is every indication that the Bureau's program in this field is filling a definite need.

PUBLICATION AND REFERENCE SERVICES

The Bureau has, since 1922, published and distributed throughout the Americas, a monthly bulletin on the many aspects of public health, *Boletin de la Oficina Sanitaria Panamericana*. Numerous special publications are issued frequently by the Editorial Section, including the Spanish editions of WHO periodicals and reports. The publication of proceedings and reports of the Pan American Sanitary Conferences, as well as of other international meetings, are the responsibility of the Bureau.

The library of the Bureau contains a highly specialized and valuable collection of more than 30,000 medical, technical, and scientific books and pamphlets, as well as documents relating to the work of PASB. Reference materials are supplied by this library to health officers of Member Governments, to individuals upon request, to staff members of WHO/PASB in the Regional Office, and to field workers through the zone offices.

The foregoing gives some idea of the nature and scope of the work of PASB and WHO in the Region of the Americas. Many other projects are still in the formative stage and may become realities in the near future.

Management of Contagious (Infectious) Diseases of Childhood

1. SPECIFIC IMMUNIZATION THERAPY*

Jean Crump, M.D., Elizabeth Kirk Rose, M.D., Katherine Boucot, M.D., and Lois Hammond, M.D.

In October 1951 the JOURNAL OF THE AMERICAN MEDICAL WOMEN'S ASSOCIATION published an excellent article on "Immunization Procedures" by Dr. Morris Greenberg. In his article, Dr. Greenberg discusses problems of immunity, and specific measures against certain important diseases.

In our discussion, we wish to stress the method of immunizing children against the so-called "diseases of childhood," and bring to your attention the problems peculiar to the allergic child. We will also consider briefly recent studies that are being carried on in connection with diseases such as anterior poliomyelitis and mumps.

Dr. Rose: Only because of the inevitable changes inherent in medical progress does it seem justifiable to discuss the present status of prophylactic procedures, well knowing that tomorrow may present a different picture.

The stream of leaflets from pharmaceutical houses and the reviews in the medical literature[1,2,3] suggest the advantages of looking for descriptions of new procedures in a regularly issued statement, representative of broad experience and research, such as the reports of the Committee on Immunization and Therapeutic Procedures of The American Academy of Pediatrics.[4] The latest report or "Red Book" from this group, should be a sine qua non for every physician interested or active in immunization programs.

DIPHTHERIA, PERTUSSIS, AND TETANUS PROTECTION

Since 30 to 50 percent of the adult population is susceptible to diphtheria and since newborn infants of susceptible[5] mothers likewise have no protection against this disease, immunization[6] should be started in early infancy. The relatively greater severity of pertussis in infants also indicates early need for protection against this disease. The effectiveness of, and tolerance to, tetanus immunization merits its early use.

At present, improvement in the purity of diphtheria toxoid and the increased antigenic response either to alum precipitated or to aluminum hydroxide absorbed form minimize reactions. No increase in reactions has been shown when the antigens of diphtheria, pertussis, and tetanus are combined. In fact, an adjuvant effect has been demonstrated when such products are used in infants and young children. Moreover, it has been shown that when immunizations are performed before the age of 8 months there is little memory of the trauma. Beyond the age of 4 to 5 years, however, the use of single antigens seems to produce fewer reactions.

No one schedule and no one product is essential. A certain degree of flexibility should be maintained. Single antigens, combinations such as diphtheria and tetanus toxoids, diphtheria toxoid and pertussis vaccine, or a combination of the three, may be employed. An increasingly satisfactory experience is being evidenced with the use of the combination; however, some prefer to give pertussis vaccine in 3 or 4 small doses at monthly intervals starting at 2 months. This is then followed in the second half of the first year of life by 2 doses of a combined diphtheria and tetanus toxoid at an interval of either two or three months.

Whichever method is used, a subsequent recall or booster dose of the various antigens given after an interval of one year, subsequently at 3-or 4-year intervals, serves to maintain a protective antibody level in the child. Thus, young children may be continuously protected by diphtheria toxoid (alum precipitated) 0.1 cc. at 3-or 4-year intervals; and tetanus toxoid (alum precipitated) 0.5 cc. at 3-or 4-year intervals or after exposure; and pertussis vaccine (saline) 1.0 cc., at any age, after exposure

*This is the first of a series of articles on the Management of Contagious Diseases of Childhood.

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or during an epidemic. Such a scheme obviates the necessity for routine Schick testing. This test is useful for older children, those with an uncertain immunization history, and those who might be suddenly or frequently exposed, such as children admitted for institutional care or student nurses who are to serve in a communicable disease hospital.

Rapid immunization against pertussis in susceptible exposed infants may be attained by 3 weekly doses (1.0, 1.5, 1.5 cc.) of the saline vaccine containing 15 to 20 billion organisms per cubic centimeter.

Older children and Schick-positive adults may be actively immunized against diphtheria, using a purified fluid toxoid by giving 0.1 cc.; followed in 3 to 5 days, if no reaction, by 0.3 to 0.5 cc.; and if no reaction, 3 to 4 weeks later, by 0.5 cc. Any reaction would indicate no increase, or even reduction, in subsequent dosage. Reactions may be avoided or minimized if one needle only is used on the supply bottle, the material is well shaken just before withdrawal, the injection given deep subcutaneously or intramuscularly, and followed by a bubble of air to clear the needle track.

Dr. Crump: In allergic children it is important that a control test also be made when a Schick test is indicated. This is essential in order to evaluate properly the Schick test.

Smallpox Vaccination

Dr. Rose: The relative absence of complications, such as encephalitis, in young infants has resulted in general approval of vaccination before 1 year of age. Current experimental work suggests a more stable form of vaccine in the future.

Dr. Crump: Vaccination against smallpox may be carried out as usual in the allergic child, with a single exception. This is a very important exception. *No child with eczema may be vaccinated.* Failure to observe this regulation may result in very serious illness or death.[9]

One must go even further and plan for the removal of the child with eczema from the house, should any other member of the family be vaccinated. Equally serious results may follow failure to observe this routine.

As soon as the eczema has cleared up entirely and remained clear for several months, the child may be vaccinated.

Dr. Crump: Rapid strides are being made in the mitigation or prevention of other diseases of childhood. Many of these new materials provide only temporary immunity, but should be mentioned here.

Mumps

Dr. Hammond: Because mumps in children before puberty is ordinarily a benign disease, its prevention and treatment have not been considered a major immunologic problem. There are available both a mumps skin test material and a mumps vaccine.[9] The mumps skin test antigen is used intracutaneously for a dermal sensitivity test. A positive reaction consisting of an area of erythema 14 mm. or more is considered evidence of immunity, and is accurate in at least 90 percent of the cases.

A chorio-allantoic vaccine against mumps is available, and is effective even when used immediately after exposure. This produces an active immunity to the disease. Since transplacental immunity is effective for the first 6 to 7 months it might be expected that gamma globulin would be effective. However, the ordinary pooled gamma globulin has been found of no use in either prevention or treatment of mumps. Gamma globulin made from convalescent mumps patients has been found effective, both in giving a passive immunity and in treatment of the disease with prevention of complications. However, it is not available commercially.

The main field for prevention of mumps is in exposed adult males where the incidence of orchitis is high. A skin test should first be done, and if this is negative, showing no immunity, then active immunization with the mumps vaccine should be carried out. This same procedure is worth considering in boys approaching puberty, who have not had the disease.

Measles

Dr. Hammond: The use of gamma globulin in the prevention and attenuation of measles is well proved. Complete protection may be obtained with the use of gamma globulin in dosages of 0.2 to 0.22 cc. per kg. of body weight, given in the first week after exposure. Modification of this disease is usually successful when gamma globulin is used in dosages of 0.04 to 0.055 cc. per kg. of body weight, again used in the first week following exposure. If the gamma globulin is used later in the incubation or early prodromal period, dosages 10 to 20 times as great as the normal amounts may modify the disease and possibly prevent complications.[10,11]

Epidemic Hepatitis

Gamma globulin also offers hope in epidemics of hepatitis. At present probably the same dosages as used for measles, again given early in the incubation period, are indicated. There is a probability that given later or in the preicteric stage, the disease may be attenuated.[12]

Gamma globulin is useless in the prevention of varicella or epidemic infantile diarrhea.

Dr. Crump: Varicella in a household also requires

the exclusion of a child with eczema. The child exhibiting skin allergy is peculiarly sensitive to viral infection, and, just as in the case of vaccination, must be removed from the home if another child in the house develops chickenpox.[8]

Poliomyelitis

Dr. Crump: No specific immunization therapy has been offered to date, but this discussion would not be complete unless we brought to your attention the studies that are now being carried on in various parts of the country with gamma globulin. Attempts to prepare a polio virus vaccine continue, and are perhaps closer to being successful than at any previous time.[13,14]

BCG and Prevention of Tuberculosis

Dr. Rose: BCG (Bacillus Calmette-Guerin) vaccination is still a controversial issue in some parts of this country. The careful studies of Aaronson[9] suggest its worth in infants and other tuberculin-negative individuals who may be frequently exposed. The mass studies of WHO now in progress should supply more facts on this subject as time goes on.

Dr. Boucot: The bases for the prevention of tuberculosis remain early case finding, isolation of the infectious case, rehabilitation of treated cases to insure against relapses, and supervision of known cases to detect reactivation early. To these fundamental procedures we may add BCG vaccination provided the limitations and controversial aspects of the procedure are understood.

BCG vaccination reduces the serious sequellae that may follow primary infection with the tubercle bacillus: pleural effusion, massive caseation of hilar nodes, and miliary and meningeal tuberculosis. Absolute immunity is not conferred and vaccination should never be used in lieu of proved means for tuberculosis control.

Controversial aspects regarding vaccination center on the following questions. Is a positive reaction to tuberculin an asset or a liability? Is it wise to abolish the diagnostic value of the tuberculin test by artificial conversion? Is it safe to infect humans with viable tubercle bacilli even though the bovine tubercle bacilli used are attenuated?

Definitive answers to these points are difficult because of the lack of controlled studies. While it is true that phthisis cannot develop unless the tuberculin test is positive, it is also true that the mortality in the young is largely due to prompt progression of dissemination of the primary infection. While there is considerable diagnostic assistance to be obtained from a negative tuberculin test in ruling out tuberculosis, it is possible that the arguments against BCG vaccination on the grounds of tuberculin conversion are largely academic. It may still be stated that no single human death from tuberculosis has been traced to BCG vaccination.[15] A well-balanced presentation may be found in the seminar on BCG of the 1947 meeting of the National Tuberculosis Association.[16]

Complications are few except for temporary local ulceration. In those occasional cases with troublesome regional lymphadenopathy there may occur breakdown with drainage. If the latter persists, streptomycin therapy may be indicated.

Reversion to negativity to tuberculin occurs at varying periods after vaccination. Revaccination is then indicated.

Large scale BCG vaccination programs are now being conducted under the auspices of WHO. Ultimately they should provide a sound basis for evaluating the role of BCG. Meanwhile one cannot but be impressed by Aronson's work[17] with the American Indians, despite the fact that it is not certain his findings are applicable to less susceptible and less exposed groups. Hertzberg[18] found the mortality rate for the unvaccinated in the Oslo population 0.6 in contrast to 0.1 for a group of vaccinated individuals.

The current attitude in the United States seems sound. BCG vaccination is recommended only for tuberculin-negative individuals among groups who, by the nature of their contacts, will inevitably be heavily exposed to the tubercle bacillus. This includes newborn children from homes of tuberculous individuals, nurses, medical students, and members of sanatorium staffs.

Allergic Child

Dr. Crump: Immunization of the allergic child, or even what might be termed the potentially allergic child, frequently presents a difficult problem. Such severe and serious reactions occur at times that the mother is told that her child cannot be immunized. In our experience there is no child who cannot be given preventive therapy. The problem is very difficult at times but it can be overcome. Each pediatric allergist doubtless has his own method of handling such cases, but we should like to offer our own approach to this problem.

As the allergic child appears for immunization, we first attempt to give him diphtheria-pertussis-tetanus antigens by subcutaneous administration of 0.05 cc. The child remains under observation in the office for half an hour and if there is no untoward reaction, he returns to his home. If there is no delayed reaction, i.e. temperature rise, malaise, or local reaction at site of injection, the following week the child receives 0.1 cc. The dosage is then doubled,

if no reaction occurs, at weekly intervals until the required amount of antigen is given. Should even a slight reaction appear after any given dose, the quantity of the subsequent dose is reduced.

In some cases, however, even the initial dose of 0.05 cc. is more than the child can tolerate without reaction. Such children can usually be treated by being given small doses of each individual antigen at weekly intervals.

In very sensitive cases it is possible at times to continue the immunization of the child by adding 1 or 2 minims of Adrenalin®. This should be put in the same syringe with the antigen.

If the subcutaneous routes continue to produce reaction, we then turn to the intracutaneous method of administration, as it has been repeatedly proved that the skin is an excellent immunizing agent, and complete protection of the child may be easily obtained by this method.[19,20,21] However, no single dose should exceed 0.1 cc., which, intracutaneously, will produce results comparable to dosages of 0.5 cc. or 1 cc. given subcutaneously.

Records

Dr. Rose: We cannot close without a plea for the improvement of physicians' records relating to immunization of patients. Parents, school medical services, to say nothing of the patient himself, are too often handicapped and the child jeopardized by paucity of data. Every parent, assisted by the physician, should keep an up-to-date record of the child's immunizations. It is hoped that some day every person in this country will possess some kind of small card to contain this data, in addition to blood type and other significant health facts.

Sumario

El niño debe protegerse contra la difteria y la tos ferina, durante el primer año de vida. Las formas de protección pueden administrarse una a una, o en combinacion. Puede mantenerse la inmunidad con dosis mantenedoras administradas a intérvalos de tres a cuatro años.

La vacunacion antivariólica debe darse durante el primer año de vida, exceptuando en los casos de niños que tienen eczema, a los cuales no debe vacunarse hasta que el eczema ha desaparecido. Los lactantes eczematosos deben alejarse de cualquier contacto con personas recientemente vacunadas, o con personas enfermas de varicela.

Para las parotitis puede usarse un antígeno para la prueba de la piel y una vacuna. La vacuna se recomienda solamente para los varones adultos.

La globulina gamma tiene un valor evidente para la prevención o la atenuación del sarrampión y de la hepatitis infecciosa. No esta disponible todavía la inmunización contra la varicela y la poliomielitis.

Faltan estudios organizados de investigación sobre la eficacia de la vacuna BCG en la tuberculosis. Parece reducir las reacciones secundarias de la infección primaria, y debe administrarse a los individuos tuberculina-negativos que estarán expuestos frecuentemente a la enfermedad.

En el niño alérgico, la inmunización puede llevarse a cabo usando dosis pequeñas y repetidas, añadiendo adrenalina a la vacuna, usando la via intravenosa.

Tanto los pacientes como los médicos deben martener un recuento completo de todas las inmunizaciones.

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Nutrition and the Inca

Aurora Revilla, M.D.

FORTUNATELY the time has passed when instinct was the only guide to what and when to eat. The experience acquired through centuries of human existence and, above all, the observations gathered during periods of war in different countries have attracted the attention of scientists and have made nutritional problems the theme for more intensive study. As a result of this there has been established the modern concept of nutrition and food values. The direct influence of these factors on the physical and intellectual vigor of a people is being correlated with history.

In countries better equipped than Bolivia it has been possible to conduct experimental studies of the subject. The National Institute of Nutrition of Buenos Aires showed that dietary errors maintained for several generations of rats will produce observable deficiencies in the offspring and result in sterility, thus ending the line with the fourth generation.

In Bolivia it has not been possible to make laboratory studies, but observations of the native Indian race have given comparable findings. The same Indian, who before the Spanish Conquest was able to establish a culture on a level that has not been reached since, is now physically degenerated and materially and spiritually impoverished. This would not, in itself, be proof of the influence of nutrition and diet, but formal studies in this direction show a striking coincidence.

There has been a marked change in dietary habits since the days of the Spanish Conquest. Previous to this, cultivation of the soil and care of the crops was the main employment, and food products of this nature were relatively abundant. The Spaniards turned the Incas from the land to exploit the mines and encouraged the use of alcohol, rather than of food.

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Somewhat over a hundred years ago the Indians gained political freedom, but still they remained chiefly miners, leaving the land uncultivated. Now 50 percent of the food must be imported, and even so 90 percent of the population have deficient diets.

Other factors besides insufficient production of food have contributed to this nutritional deficiency, such as exodus from the agricultural areas, lack of roads of communication, devaluation of our money, inadequate remuneration of the laborer, undesirable food habits, and lack of knowledge of elementary nutritional facts. Indifference to these vital problems is now being slowly changed.

In 1947 the Minister of Labor appointed a technical committee, under the supervision and on the advice of the author, to study national group diets. Studies were conducted from 1948 through 1951 with the following groups: the mining centers of Catavi, Siglo Veinte, and Potosi; and the industrial section of La Paz City. The results are shown in the table. Food values are adjusted to international standards with some deviations due to local variations and to the inclusion of a few typically Bolivian foods, such as chuno (frozen dehydrated potato), oca (edible oxalis subterranean stem), and papalisa.

The diet analyzed in the table applies to the adult working man who, under hardship conditions, usually gets the best food. This very evident food deficiency is reflected in the output of labor as compared with work results of other national groups.

What is meant by the decay of the Indian for which we feel his poor diet is responsible? Two descriptions by observers who wrote their statements forty years apart will be illustrative. Franz Tamayo wrote in 1910, "He will always be a willing farmer, particularly if he is taught modern methods. His physical strength makes him an excellent miner. His willingness to accept organized action and discipline, and his morality, make him an ideal soldier, probably superior to any in Europe. Soldier, miner, farmer—a wise education ought to develop these three types of men among the Indians."

Forty years later Juan Manuel Balcazar, the physician, had cause to describe the Indian as fol-

TABLE OF DIETS CONSUMED BY BOLIVIAN WORKERS
By Percentage of Members of the Group

Dietary Intake	Miners 1948	Industrial Workers 1949	1951
Habitual use of alcoholic drinks	100	72	3
Daily intake of essential factors			
Animal protein, 30 to 50 Gm.	10	69	33
Meat, 150 to 250 Gm.	5	68	33
Calcium, less than 0.5 Gm.	100	99	86
Phosphorus, less than 1.0 Gm.	85	75	63
Iron, less than 10 mg.	15	31	40
Vitamin B_1, less than 0.5 mg.	5	18	16
Vitamin C, less than 50 mg.	90	84	30
Essential foods absent			
Eggs	95	90	93
Milk	75	81	63
Daily intake in calories			
Total calories:-1000 to 1500	10	36	30
Total calories: 1500 to 2000	60	36	30
Distribut'on of calories			
Carbohydrates: 70% or over	75	25	46
Fats: less than 30%	100	59	50
Proteins: 12 to 15%	75	40	53

lows: "The classical Inca virtues expressed in the ancient salutation of 'ama sua, ama llulla, ama quelle' are being forgotten. The Indian, especially of the northern part of the country, is inclined to stealing, lying, and laziness. He is more likely to harm than help the stranger. His unusual physical strength that made him famous in ancient times, both as a soldier and runner of the Inca mail, is passing into the sphere of myth. His abstinence, another virtue once possessed by the Indian, is disappearing. He still can manage if there is no food nor drink at hand, but otherwise he will overeat and overdrink. But if the food and drink is his own he uses it very sparingly."

Undernutrition, maintained through several generations, is no doubt the primary reason for the delayed material and spiritual progress of the people. In addition to the ill health of the adult, and poor work production, brought about by malnutrition, there is a very high infant mortality. Various agencies of the Government have attempted solutions for the undesirable nutritional problem, some successful and others not. Food imports have been increased, but by the same token so also has the national debt. Nutritional customs have not, to date, been studied because of insufficient knowledge of their importance. Wages are being brought to conform more nearly to minimal standards of living. Better agricultural methods and instruction of the Indian in the use of modern farm machinery are being sought. The sources of protein foods are being improved by the increase of livestock reserve, as well as the stocking of rivers and lakes with fish. Improvement of roads between the areas of production and consumption is taking place, particularly in the East.

There is at present in Bolivia an educational campaign which will encourage the people to raise a useful variety of crops, and also, on the home level, to use their food budgets wisely and to prepare their meals in ways yielding the best nutrition. Bolivia is trying to solve her nutritional problem through co-ordinating the efforts of a large number of agencies.

Escadero in his book, "The Present and Future of Nutritional Problems in Bolivia," says: "I believe in the prospering of Bolivia and in its people. Because of its early history it is a country whose people have progressed more slowly than other American peoples. The physical conditions of the high plains, the rich history of the races that fused in its formation, and its geographic position, justify the hope that it will eventually be a nation with continental influence. In order that America shall arrive at a position of world influence as a compass of peace and of work it is indispensable that each one of the countries that form this continent be comparable in strength and learning. The strength of a brotherhood of nations is as strong as its weakest link."

SUMARIO*

Son analizados los factores que contribuyeron a la progresiva decadencia del indio boliviano. Se demuestra la repercusión que tienen los errores de alimentación serios y mantenidos por largo tiempo, hecho que fuera previamente comprobado por el Instituto Nacional de la Nutrición de Buenos Aires, Argentina en ratas sometidas experimentalmente a dietas de carencia.

El resultado de las anamnesis alimentarias levantadas entre obreros de diversos centros mineros y fabriles de Bolivia desde 1948 a 1951 demuestra la existencia de subalimentación en un 90 por ciento de ellos.

Se sintetizan los factores causales de esa subalimentación y se ennumeran las medidas adoptadas por el Estado para corregirlos.

Un plan de acción es presentado:

1. Tender hacia una mayor productión agrí cola.
2. Incrementar la piscicultura.
3. Establecer vías de comunicación entre las zonas de producción y de consumo.
4. Divulgar los preceptos de la alimentación correcta por todos los medios de publicidad y enseñanza.
5. Fijar los salarios con criterio biológico.

*This summary in Spanish was written by Dra. Blanca Nelly Povoli de Smith.

Salmonellosis

DIAGNOSTIC AND IMMUNOLOGIC CONSIDERATIONS

Josefina Berrayarza León, M.D.

Historical Background

THE SALMONELLAS are gram-negative organisms which, in the modern bacteriologic classification, are included in the family of Enterobacteriaceae, tribe of Salmonellae, genus Salmonella. The species and antigenic types included in this group are numerous: 209 can be serologically classified according to the 1951 outline of Kauffmann and White.

The first Salmonella to be isolated was S. choleraesuis, by Salmon and Smith in 1885,[11] in a case of cholera in a pig (today we know that this infection in pigs is caused by a virus with S. choleraesuis as an important secondary invader); in 1888, S. enteritidis was isolated in Germany; in 1892, Loeffler isolated S. typhimurium which is, statistically speaking, the most frequent cause of human alimentary toxicosis of the Salmonella type.[25] S. typhosa was found by Eberth in 1880 . . . and Gaffky isolated it in 1884 . . . One of the outstanding characteristics that differentiate this Salmonella from others of the species is its incapacity to form gas from fermented carbohydrates and the fact that human beings are its only hosts . . .

Many species of Salmonella are pathogenic to man and the clinical symptoms they cause are varied and numerous ranging from alimentary toxicosis, gastroenteritis, to the most severe septicemic conditions. Species of Salmonella have been isolated in cases of coleocystitis, appendicitis, osteomyelitis, endocarditis, pneumonia, pulmonary abscesses, and meningitis. Consequently when we are faced with a picture of clinical symptoms that makes us suspect salmonellosis, an investigation is indicated, and the clinical diagnosis confirmed by the bacteriologic and serologic findings in the laboratory.

Laboratory Procedures

The bacteriologic diagnosis is based on the isolation and identification of the organism. It can be searched for in the blood, in the feces, in the

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urine, in the bile, in the spinal fluid, and less frequently in the secretions from the nasopharyngeal area and in other waste products of the body.

This confirmation by bacteriologic findings is indispensable not only in the case of ill patients, but also—and this is even more important from the public health point of view—in the case of carriers, whether they are convalescent, chronically infected or passive carriers. Seligmann and his collaborators[25] found carriers of Salmonella among healthy persons handling food, engaged in nursing, and assisting in food preparation in hospitals. It is possible that the most common source of infection from Salmonella is the human carrier. Improved methods of laboratory culture have shown that from 2 to 5 percent of apparently healthy persons are carriers.[23]

The two bacteriologic examinations most frequently carried out because they give the most positive results are: examination of the blood and examination of the feces, followed by examination of the urine and bile. The last two are especially important in examining carriers.

Examination of the Blood

The isolation of species of Salmonella that have invaded the blood stream (S. typhosa, S. paratyphi A, S. paratyphi B, and others) is generally possible during the first week of the disease since during that period the percentage of positive findings is highest; in typhic salmonellosis, for example, these positive findings reach 90 percent. It can be said that examination of the blood is the first bacteriologic investigation that should be done, since bacteremia appears in the first days of the disease . . .*

Examination of the Feces

Examination of the feces can sometimes give positive results even during the incubation period of the disease before clinical symptoms have appeared. This examination is carried out, generally, during the first 10 days after the onset of the disease, and the percentage of positive findings increases until it reaches 80 to 90 percent in the second or third week. The possibility of finding species of Salmonella in the feces decreases during convalescence.

To make the examination, the sample should be fresh; if possible, it should be taken directly, with rectal cotton swab or with rectoscope, and seeded immediately. If this is not possible, it should be kept in the refrigerator, until examined, using one of the preservatives recommended for such cases (glycerine, for example) . . .*

*At this point the original manuscript inserts detailed directions for making laboratory examinations. Editor.

Examination of Urine and Bile

These two bacteriologic examinations are very useful in uncovering Salmonella carriers (S. typhosa is frequently found in the gallbladder) and also in cases of atypical typhoid fever with negative blood cultures and doubtful agglutination reactions.

Cultures of the urine are generally made during the third and fourth weeks as at that time they can give us up to 60 percent of positive findings; in carriers this percentage is somewhat lower . . .*

Culture of Spinal Fluid from the Medulla

In some American countries, as for instance in Brazil, cultures are made of spinal fluid from the medulla with a view to isolating species of Salmonella. Barros Barreto gives the following results: during the first week, 60 percent of the findings are positive; during the second week, 52 percent; during the third week, 48 percent; and 35 percent after the third week.[12]

All these bacteriologic examinations are necessary in reaching a correct and scientific diagnosis of any case of Salmonella, and they are indispensable in searching for human carriers. Drigalski, in 1904, established the existence of Salmonella carriers on bacteriologic evidence.

Detection of S. typhosa in Water

Quite independent of the need for isolation of Salmonella from the fluids of the body in the diagnosis of Salmonella in patients and carriers is the extreme importance (from the public health viewpoint) of detecting S. typhosa in water. We know that the bacteriologic study of water available for consumption by the population must be a matter of routine for the sanitation department and that among the organisms that can be found in water are the Salmonellas, mainly S. typhosa. Today there seems to be a method for isolating this Salmonella from the water supply. We refer to the "Filters with Filtrating Membrane of Zsigmondy and Bachman." . . . Dr. Alexander Goetz reports on their satisfactory use in Europe.[26]

Salmonellas Most Frequently Found In Mexico

The Salmonellas of human origin most frequently found in Mexico by Dr. A. P. León, who made such an analysis of the blood and feces of patients with a clinical picture of typhoid in 1946, are: S. typhosa, S. paratyphi A, S. paratyphi B, S. london, S. thompson, S. barelli, S. reading, S. saint paul, S. typhimurium, and S. choleraesuis.[14]

According to the recent work of Dr. Valera and Dr. Olarte (1951), who investigated the Salmonellas of human and animal origin, the most frequent

in a study of the feces of 1,075 individuals, apparently healthy, were: S. typhosa, S. typhimurium, S. derby, S. anatis, S. newport, S. newington, S. choleraesuis, S. muenchen, S. enteritidis (Danish strain), S. paratyphi B, S. paratyphi A. S. enteridis, S. chester, S. montevideo, S. pond, S. new brunswick, S. oranienburg, S. thompson, S. pensacola, and others[24] . . .**

Immunologic Considerations

Bretoneau was the first to observe that persons afflicted with typhoid fever did not contract the disease a second time, in other words as early as 1829 he deduced that the disease conferred immunity. Many years later, in 1887, Beumer and Peiper demonstrated the existence of immunity on an experimental basis in research carried out with white mice. Still later, in 1896, Durham and Gruber demonstrated the presence of specific agglutinants in the blood of laboratory animals (rabbits) injected with typhoid organisms.

In human beings there is no natural immunity to the Salmonellas although it has been proved that there are racial differences as to susceptibility: the yellow races and the Hindus are slightly refractory to salmonellosis, while persons of the white and Negro races are extremely sensitive to it.

Salmonellosis produces an active acquired immunity in the body which has suffered an invasion of these organisms, and we say that it is "solid" because the disease is rarely contracted again.

The stimulation of active immunity is now a public health measure. Antityphoid vaccination was first tried on animals. Fraenkel and Simmonds[31] carried out their experiments on rabbits in 1886; Beumer and Peiper used white mice. In 1888, Chentemesse and Widal[31] vaccinated white mice with organisms killed by heat. Later came the preventive vaccination of human beings; Pfeiffer and Kelle in Germany and Wright in England.[31]

Wright used strains of typhoid organisms killed by heat, enrolling two human volunteers for his experiment. The dead organisms were injected at intervals to create three separate stimuli to body defenses. Twenty days after the last injection he gave them live organisms and observed that the disease was not produced.

In 1902, Besredka used a sensitized vaccine for the first time with typhoid organisms impregnated in antityphoid serum. Vincent, in 1910, prepared a polyvaccine that was used by the troops in Algeria, Tunis, and Marruecos with excellent results.[31]

During World War I (1914-1918) typhoid syndromes appeared in persons who had been vaccinated and this aroused doubts about the effectiveness of antityphoid vaccine. But the studies of Widal and Vincent showed that the syndromes were caused by S. paratyphi A and S. paratyphi B and that these two Salmonellas had to be added to the antityphoid vaccine. With mixed vaccine (TAB and TABC) the epidemics of typhoid and paratyphoid were practically wiped out from the fields of battle and the effectiveness of preventive measures definitely established. Today this vaccination is compulsory for all armies of all civilized countries and for groups of the civilian population among whom, due to special circumstances, the propagation of these diseases is likely.

When the techniques for typhoid vaccination were first established, only typhoid organisms were employed and partial success was obtained as confirmed by Russell, a sanitarian who, in March 1909, began the vaccination of United States Army troops with vaccines obtained from the "strain Rawlings" (the vaccination procedure was at first placed upon a voluntary basis; later, in March 1911, it became compulsory). When 60,000 soldiers were vaccinated it was observed that morbidity rates of 3.03 percent were reduced in three years to 0.26 percent and the former mortality of 0.28 percent was reduced to 0.03 percent.[31]

A statistical study carried out on the basis of observations made from 1906 to 1935 gives the following mortality rates per 100,000 in the United States:[4]

Years	Rates (Civil Population)	Rates (Army)
1906-1910	25.6	26.37
1911-1915	16.6	3.24
1916-1920	11.1	5.08
1921-1925	7.6	0.40
1926-1930	5.1	1.19
1931-1935	3.5	0.59

These data are sufficiently objective and convincing to establish the importance of antityphoid vaccination and the need for requiring it in countries which, like Cuba, have deficiencies in sanitary engineering and in the control of carriers.

There are several modes of administering antityphoid vaccine: orally, which is not very effective and is used only when parenteral administration is contraindicated; and subcutaneously by means of three injections of vaccine at 1-week intervals with doses of 0.5, 1.0, and 1.0 cc. respectively.

**At this point the author's manuscript inserts some detailed observations of serologic investigations—the Widal reaction, and the Complement Fixation reaction. Editor.

A consideration of the entigentic structure of the Salmonellas follows. Editor.

Subcutaneous injections are the most widely used method of administration . . . Intradermal injections are frequently used in the United States and in Cuba. We use three doses at 8-day intervals, the first of 0.05, the second of 0.1, and the last 0.2 cc.

Dr. Batson and Dr. Landy" presented at the annual meeting of the American Public Health Association in 1949 their experiments with subcutaneous administration of the vaccine by means of a "subcutaneous atomizer" which projects the liquid through the skin. . . .

The initial vaccination or the establishment of immunity is important, but even more so is the annual re-vaccination . . . although the key to eradication of endemic typhoid resides in environmental sanitation through engineering works and the efficient control of carriers.

Sumario

Desde las ultimas decadas del siglo pasado, cuando las solmonelas empezaron a ser aisladas por los investigadores de la epoca, hasta la modern clasificacion serologica de estos germenes llevada a cabo por Kauffman White en 1951, se ha recorrido un gran camino y realizado un enorme progreso en el diagnostico y prevencion de las salmonelosis.

Las tecnicas modernas de laboratorio permiten aislar e identificar el germen por medio de hemocultivos, coprocultivos, bilicultivos, y examenes de las secreciones de la narizy faringe, y de otros productos organicos. El porcentaje de resultados positivos que estos examenes producen es elevado: pueden llegar hasta un 80 a 90% en el caso de los hemo y coprocultivos. Estos metodos permiten no solo diagnosticar el paciente, sino tambien descubrir al portador, que constituye quiza "la fuente mas comun de salmonelosis."

A estas tecnicas se añaden hoy otras mas recientes, como la le los medulacultivos, que se practica en el Brasil, asi como en otros paises americanos; y la del nuevo metodo de aislar rapidmente la S. typhosa de un gran volumen de agua por medio del "Filtrador de membrana Filtrante de Zsigmondy y Bachman."

La persona humana no posee inmunidad natural contra las salmonelas, aunque las diversas razas presentan diversos grados de sensibilidad a ellas: la raza negra y la blanca son las mas susceptibles.

Las vacunaciones contra las salmonemlosis, se iniciaron en 1886, cuando se llevaron a cabo las primeras tentativas de inmunizacion artificial. El Ejercito de los Estados Unidos adopto la vacunacion anti-tifica, por primera vez en 1909, y durante la primera guerra mundial, de 1914 a 1918, gracias a las vacunaciones en gran escala, se eliminaron practicamente las epidemias de los campos de batalla.

Hoy las inmunizaciones continuan siendo una gran medida de proteccion, pero la eliminacion final de varias salmonelosis endemicos tiene que obtenerse a base de programas de salubridad, ingenieria sanitaria, limpieza del medio ambiente, y control de los portadores.

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Medical Practice in Bolivia

PERIOD OF CULTURAL TRANSITION

Ruth Wreszinski Tichauer, M.D.

BOLIVIA, the tin country of South America, best known for its high altitude and fabulous rainbow trout, has its own special medical problems. Doctors have been particularly concerned with the medical education of patients; not those from the middle and upper classes—businessmen, teachers, executives, who are the same everywhere—but the Indian masses Bolivia has handed to us in her sudden effort to incorporate them into her general culture.

These patients are unused to the ways of getting into and out of a doctor's office, ignorant of the usual forms of payment, and unaware of what is meant by a general physical examination or by laboratory tests. Yet in their expectation of a physician's ability the sky is the limit or even higher.

Witness this writer's experience some months ago when, on arriving in a small hut, she was introduced to her patient, an old woman who lay quietly under a cloth with candles burning at right and left, having been dead for several hours. Luck was with the doctor this time because, on superficial palpation, she found a few hard and knotty lymphatic glands in the cervical region which guided her to the mammary cancer. With that knowledge she examined the five elderly daughters and was able to locate a beginning tumor in one of them.

Dra. Tichauer was called to Bolivia in 1940 to be Professor of Social Medicine at the University of Suer, and has held appointments in the field of nutrition and social service in several Government agencies.

Bolivian patients have their own way of connecting cause and effect. One patient, a young tractor mechanic, in commenting upon the unusual cold spell during the preceding week said: "Probably some religious feast." Such connections extend upward and downward in both the material and spiritual world. Intestinal parasites, for example, are believed to come from candy; dyspnea and precordial distress from watching someone eat a delicacy you would have liked to taste yourself, or from sorrow; difficult labor may be the consequence of permitting the woman to do her own cooking during pregnancy. Babies are fed the strangest things: toasted crude beans, sauces hot with pepper and spices, and what not, in the belief that such a course avoids the heartbreak which might result from their wanting these things very badly and being denied them.

Food taboos are difficult to surmount when teaching good nutrition. Orange juice, the main source of vitamin C in our country, is believed to be bad for a cough, and is to be avoided when fever is present. As a result, illnesses of long duration are usually complicated by vitamin C deficiency. One little girl, who had had whooping cough for three months, came to the office all dressed up in a beautiful silk dress but bleeding from the nose and gums and with a considerable degree of secondary anemia. Evidently the precaution of avoiding oranges during a cough had been scrupulously followed. A doctor cannot express his disbelief in ideas which are so well established, but he can say that orange juice should be given during a cough, even though it

may seem to make it worse, because it will get the phlegm out of the chest.

In prescriptions, three and seven are good numbers to use. A pressure dressing may be left on twice seven or three times seven days. Calcium may be taken three times a day. Unfortunately, antibiotics cannot often be pressed into such a system of popular numbers, but black dogs may help. One cure was attributed to our Doberman pinscher who happened to be in the office during a patient's visit.

Naturally, there is competition with witch doctors. When the butcher asks me, "Do you want a tenderloin, *yatiri?*" he is expressing a compliment. To have used the word *kolliri* in addressing me would have been even better, since the *kolliri* is believed to effect cures by means of medicines, such as herbs, dead frogs, and the like, while the *yatiri* works more with pure magic. The first of these local colleagues whom this writer met was a very charming woman, rather young, who used to come for a professional chat over a cup of hot chocolate in my kitchen. We might discuss "anu' chapi" for diarrhea, excellent before the advent of the antibiotics. Even now, at the entrance of my house, there is a scrub known as "leguminosa" with pretty white flowers which was given to me by my witch doctor friend whose name is "Happiness." Visiting Indians exchange knowing glances when they see it, because, among the natives, it is thought to be an abortive.

The next yatiri was in prison. A small white paper, no bigger than the palm of your hand, had brought him there. Many years ago he had learned his profession from his father, as is the custom, and had exercised it in his native highland. Then he heard of war in the warm lowlands to which the Government would send, without charge, anybody who wanted to go. New sights, new medicines, and new knowledge beckoned him. The nearest recruiting office did not wish to send him as a medical man, but he was given a small piece of paper and some equipment and allowed to go as a soldier. He saw the warm country with its new plants and learned all there was to learn. Then he went home. Years later "the white piece of paper" established his status as a deserter.

There is a sinister side to these native customs and taboos. Do you remember the pregnant mother who must not cook, and the feverish child who must not have a drink of orange juice, the most widely used refreshment in our country? The same punitive threat hangs over the family which does not dispose of the placenta according to complicated and partly contradictory rules. Instead of rejoicing over the birth of her baby, the new mother who has been "sick with a child" worries lest the severed cord should slip back into the womb. A terrified young mother was found lying on her bed while a tattered and dirty old woman crouched on the end of the umbilical cord to prevent it from slipping back.

In Bolivia, children may not play near small rivulets because their parents believe that big worms may come creeping out to enter their little bodies; rooms may not be cleaned in the evening because money and fortune will be swept away; charms are thrown on people and pets.

It is this pattern of basic beliefs which creates problems of mental health. Hyperacidity and gastric ulcer are frequent psychosomatic symptoms. Alcoholism and coca addiction are widespread. Immature attitudes, especially childlike dependency, are constantly observed: young men looking for a mother substitute rather than for a wife; a woman of 42 confined to a wheel chair for two years after her mother's death; and problem children with enuresis and temper tantrums in larger proportions than in areas with more stable cultures. Paralleling these attitudes of dependency are cases of strong resentment toward parents and those in positions of authority. The family of a woman patient experiencing a severe gallbladder attack was instructed as to her diet, especially the necessity of avoiding fats. The patient was worse the next day because her son had given her a full glass of oil.

In such a setting, medical education of the public is very rewarding. It is satisfying to rid people of fear by convincing them that a local epidemic of smallpox is not due to spiritual foes but to a disease which can be prevented by vaccination. Even among the witch doctors, magic is being replaced by modern drugs. I was called to treat a severe reaction from penicillin which had been prescribed by a kolliri, an Indian woman with a stiff hat and dozens of colorful petticoats. Now only licensed physicians are permitted to use penicillin but an understanding of western medicine is growing.

So here we are, physicians with modern professional preparation, sometimes laughing and sometimes angry, fighting in a struggle for progress. Our patient try to understand us as best they can even if a suppository occasionally lands in the opposite opening and is swallowed. Everybody is trying to grow up and put aside superstition. That the infant mortality rate has already been materially lowered is tangible evidence of success.

More Than One Hundred Years Ago

Elizabeth Bass, M.D.

I AM DEEPLY GRATEFUL and tremendously flattered by the honor that you have today bestowed upon me. At the same time I am very conscious that I have not really deserved or earned this recognition and tribute from my Alma Mater.

"The History of Women in Medicine," the subject assigned to me, is one that is very dear to my heart and one of boundless scope and fascination. Many years ago—more years than I care to count—I acquired an incurable habit of clipping and collecting all items that pertained to women in medicine. Gradually there developed an accumulation of press notices, letters, manuscripts, photographs, diaries, old journals, and books by and about medical women. Upon my retirement from teaching, this collection became a part of the Rudolph Matas Library of the Tulane School of Medicine, directed by Mary Louise Marshall, our guest, and my friend and associate. I may add that it is mainly through her interest and tireless effort that this mass of material has been indexed, catalogued, and made available.

It delights me no end to note that an increasing number of women physicians and students now share my interest in collecting, and I deeply appreciate their recent contributions to the history of women in medicine.

I thought that it might be of interest to you to hear of women who practiced medicine in this country during the first half of the nineteenth century. With your indulgence I shall attempt to give some cameo sketches of a few pioneers about whom little has been known. Unfortunately there are only fragmentary records of the early practitioners and a similar lack of material exists for the Colonial period, although we do have accounts of trained and able midwives who served during this provincial period. In reality these women were general practitioners but were denied the opportunity for formal training as was provided at that time in Europe where midwives were given degrees, professorships, high honors, and esteem. As early as the year 1729 women midwives were licensed in Louisiana, and throughout the New England states are gravestones that bear the names of early midwives and tributes to their services . . . there was Mrs. Samuel Fuller who came with her physician-husband on the Mayflower, Abigail Adams, Ann Eliot, Mrs. Thomas Whitmore, Ann Hutchinson, and many others who devoted their lives to midwifery and care of the sick.

The first half of the nineteenth century was indeed a dark and stormy time in American medicine. Academic medical training was available before the Revolution only in New York and Philadelphia where schools had been established. This was the era of apprenticeship. The majority of men who practiced medicine had never attended a medical school. It is recorded that of the five thousand men physicians at the time of the Revolution, only four hundred were actual doctors of medicine by degree. The custom was for a student to select an older practitioner as his preceptor, often his own father, and accompany him on calls, and compound medicines at home. The more fortunate one, after receiving a bachelor's degree and spending several years with a preceptor, would attend a brief course of lectures at some established school and then go to Europe to complete his studies. I might mention that William Shippen, Jr., studied with his father before going abroad, and it was he who in 1762 established a course for midwives where "female students were taught privately." "Men midwives" were introduced about the year 1776. Ephraim McDowell did not graduate from a medical school but in 1827 received an honorary degree from the University of Maryland. Daniel Drake's "diploma" was a certificate stating that he had completed four years of study with Dr. Goforth, although after practicing a number of years Dr. Drake earned a medical degree at the University of Pennsylvania.

Women, as we know so well, were barred from the few good medical schools that existed in these early times. I might mention also that, aside from the early seminaries, it was impossible for a woman to enter a college until 1837 when Oberlin College in Ohio opened its doors to women, becoming the first American institution offering women the ad-

This paper was read on the occasion of the bestowal on Dr. Bass of the Alumnae Achievement Award of the Woman's Medical College of Pennsylvania, Philadelphia, on June 11, 1952.

vantage of higher education. Two years later the Georgia Female College, exclusively for women students, was opened. Those women who desired to study medicine did so under preceptors and practiced as did many men without a degree or even a license.

When the need for more doctors arose, new schools sprang up like mushrooms and poorly trained practitioners were turned out in numbers. This was a sorry time in American medicine. Medical and religious cults came into being and "quackery" flourished like a weed. Eclectic, homeopathic, and hydropathic schools attracted many male students and some even invited the presence of women. Many of these so-called medical institutions were what today we might call a "racket" and were concerned mainly with making money. Such were the disturbed conditions in American medical education in the period when women were slowly awakening to the need and importance of higher education and of equal political rights.

There is little information concerning the early women practitioners, for they were very few and far between, isolated, and inconspicuous. Their story is yet to be told. I cherish the hope that some musty archives or papers from family attics or some forgotten files may someday yield light on these American pioneers whose names are now unknown and whose services are forgotten. We must endeavor to add to our meager store of knowledge and try to discover more of these, our predecessors and trailbreakers. For the history of American medical women begins far earlier than the historic year of 1849 when through great courage and persistence Elizabeth Blackwell received the first medical degree accorded a woman in this country and thereby opened the doors of American medical schools to women.

I have found a fascinating record of two women doctors of Georgia who practiced in the early part of the nineteenth century. A faded newspaper clipping from the Savannah Morning News, dated April 26, 1936, has been preserved in my collection. After extensive research, Dr. Victor Bassett found records of these interesting pioneers and published his findings in the local press. I am certain that throughout the Southern states and in frontier towns of the Western Reserve, other courageous and determined women were serving as did Dr. Mary Lavinder and Dr. Sarah E. Adams of Georgia. Would that we knew the names of others and their stories!

It was the custom in Savannah to place in the last column of the mortuary records the name of the medical attendant, and the name "Miss Lavinder" frequently appeared from the year 1805 to 1845. Mary Lavinder, third child of Benjamin and Rebecca Lavinder, was born in Savannah, October 1776, and died in that city November 19, 1845, at the age of 67 years. Her first knowledge of medicine was secured from books, borrowed probably from the library of Dr. Lemuel Kollock who may have been her preceptor. With an earnest desire to acquire further training, Dr. Lavinder traveled to Philadelphia to study with Dr. Thomas C. James, then professor of midwifery at the University of Pennsylvania Medical School. She became a private pupil of Dr. James, as women were not permitted to attend the classes where "men midwives" were receiving their training. Soon after Dr. Lavinder returned to practice in Savannah as a midwife and general practitioner, the city was stricken by three great disasters: a devastating fire, a severe tropical storm, and an epidemic of yellow fever. In addition to her strenuous medical duties, Dr. Lavinder assisted the homeless and cared for the poor as well as for her patients.

In the year 1818, a letter was received by Dr. Kollock from the noted Dr. John Collins Warren of Boston saying: "We understand that there is a well-educated female practitioner in Savannah. Perhaps you could spare her, if she is a proper person and would come. The practice we could be sure of giving her would not the first year exceed $1,000 but afterward would increase greatly in the hands of a person of good address." Dr. Lavinder's name was not mentioned in the letter but it is almost certain that Dr. Warren referred to her, and knew of her work but not her name. She refused the offer and preferred to remain with her own townsfolk, although we are sure that many regarded her as eccentric and her advanced ideas of women's rights were unheard of, for this was long before the agitation for suffrage.

At the time of Dr. Lavinder's death in 1845, there appeared in the same Savannah newspaper, an obituary notice from which I would like to quote in part: "Our whole city was shocked and astounded," the notice read, "on the morning of Thanksgiving Day to hear that this venerable lady had breathed her last during the night previous. She was one of the most extraordinary women which our state has produced. Early in life she devoted herself to the study of medicine but not content with such information as she could gather from books, she went to Philadelphia and placed herself as a private pupil under the late Professor James of the University of Pennsylvania. When she had made sufficient attainments in her art, she received the testimonials of her qualifications to practice the obstetric art. For nearly half a century she has

most devotedly continued to practice her profession living the meanwhile in every sense of the word, a life of 'single blessedness.' But successful as she undoubtedly was in her professional career, it was not by this that she was best known and will be longest remembered in our city. She was the true friend of the poor. During the fearful pestilence which laid waste to our city . . . she went about from house to house, ministering to the sick and nursing and comforting the poor, regardless of the danger of what many then considered a contagious disease."

"Every day of the year, her old-fashioned 'chair' (a low-hung carriage) with its well-known white horse (almost as old as his mistress) might be seen wending their way along the by-lands of the city, loaded with coffee and sugar and tea and 'grits,' and sometimes with mattresses and blankets for the poor. She ministered to them as doctor, nurse, housekeeper, almoner, and lastly as a ghostly comforter, and who will say that the mercies of Heaven were not best inculcated by one who, in her own aged and feeble person, so nobly illustrated mercy on earth" . . . The obituary continues at greater length. It tells of her love of truth and her intolerance especially toward the "giddy butterflies of her own sex." "Long will it be before we shall look upon her like again . . . The death of such a woman is a public calamity" . . . and finally the passage ends with a suggestion that the ladies of the city erect a monument to the memory of Dr. Mary Lavinder.

Death records show that Dr. Lavinder did medical practice for women and children as well as her midwife duties. She did not have a license, for when she returned from Philadelphia the State of Georgia had no licensing board. Dr. Bassett found in a court record that Dr. Lavinder's property included a small plantation, some slaves, medical instruments, a physic case, 37 medical books, and 79 volumes of religious and miscellaneous works.

It is known that Dr. Sarah E. Adams practiced in Augusta, Georgia, from 1821 to 1846. She had studied with private instructors and read medicine with Dr. Milton Anthony, founder of the Medical College of Georgia. She was admitted to practice and at the time of her death was mourned and honored by the people of her city. There is no record that she had a license for it was not until 1821 that the Georgia Medical Society was given authority to license practitioners and, like many men, Dr. Adams possibly received only a certificate from her instructor as to her qualifications.

Although these women doctors are but isolated examples, there were others who served as midwives and general practitioners though they were admitted to the early schools of midwifery as private pupils only. We are familiar with the work of Dr. Samuel Gregory and the school he established in 1848 where women were trained in scientific obstetrics. Dr. Gregory had protested against the instruction of male midwives and opened the Female Medical College in Boston. Among the students attending his school were the Hunt sisters, Harriet Kezia and Sarah Augusta.

I have recently reread, "Glimpses and Glances, a record of 50 years of social and 25 years of professional life," an autobiography of Harriet Hunt published in 1855. This intimate record of a noble unselfish life is one that I would like to recall, for her story mirrors so vividly and truly the conditions and hardships that confronted women who wished to study medicine before they were admitted to recognized schools or rather before they were forced to form their own schools.

Harriet and Sarah Hunt were of a distinguished Boston family and had taught school for thirty years in that city. Sarah had contracted tuberculosis and was slowly failing when by chance they met the Motts, husband and wife, who had come from England to practice in Boston. Their name was similar but this strange couple should not be confused with James Mott and his wife Lucretia, the Quaker preacher and suffragette, an outstanding woman of her time. Little is known of the background of the English Motts but their questionable tactics of extravagant claims through advertising attracted many patients and soon they had acquired a large practice. The Hunts came under the Motts' magic spell . . . and I use the word "magic" advisedly. An intimacy was formed and the two families shared a common home. Harriet was convinced that Sarah's rapid improvement in health was due to Mrs. Mott's treatment. Some years later Sarah married and died in childbirth . . . This description is a solemn chapter in Harriet's journal.

The sisters had been determined to study medicine and at first their information was gained from medical books and later from the Motts. In the year 1835 the Hunts hung out their shingle on Elm Street in Boston and before long patients made a beaten path to their door. Their practice was mainly in the office as their mother disapproved of her daughters visiting patients in their homes as midwives. They studied and practiced at the same time and while they may have lacked clear understanding of some cases, they were earnest in their efforts and devoted to their profession. Sarah had an aptitude for drawing and would copy plates from anatomical books, so that each case was carefully investigated. Harriet writes: "We studied with unwearying zeal . . . there was no physician to speak

one encouraging word to us, or to whom we could apply. So alone, unaided, we established our own code of laws and concluded not to visit patients in their homes. Many chronic cases presented themselves, also diseases of children, in the curing of which my sister always excelled me. We were called 'peculiar doctors' and there was opposition among the friends of our patients to 'lady physicians' . . . but our love for our calling gave life to the calling."

Harriet was deeply religious, a firm advocate of women's rights, and a fearless campaigner against the injustice of taxation without representation, as her journal reveals so strongly. These were the days of female lecturers, devotees of phrenology, prison reformers, temperance leaders, abolitionists and anti-abolitionists, and suffragettes. It is no small wonder that the Hunts came under new influences, that of the Motts, of Combe the phrenologist, and of Swedenborg. However, Harriet recognized the need for better medical training and in 1847 and in 1850 applied to the Harvard Medical School for permission to attend classes. Each time she was refused and states that "she will never forgive Harvard for depriving her of a thorough knowledge of general and special anatomy by witnessing dissections." Harriet was especially interested in dietetic rules, the value of bathing, and to some extent in metaphysics. She complained bitterly that medical books only taught the cure of disease and paid little attention to the cause. Perhaps she was one of the forerunners of modern day preventive medicine and even, I may add, of psychosomatic medicine.

Her journal concludes with a hopeful outlook. She was thrilled by the formation in Boston of the Lady's Physiological Society where lectures were given on hygiene. In later years she traveled to many cities and attended conventions, meeting noted women and men of those times. She expresses her great delight in the coming to Boston of other medical women—women who had graduated from medical colleges as did Dr. Nancy E. Clark in 1851, Dr. Martha A. Sawin, Dr. Sarah Adamson, and others. She was gladdened by the success of Dr. Elizabeth Blackwell and impressed with Dr. Marie Zakrezewska as a woman of "noble bearing and scientific mind" who "came from the old world with its experiences and treasures to cast her lot in the new." She mentions a Dr. Mary S. Gove who died in 1838 and whose knowledge of anatomy and physiology fitted her for her lectures "as a physician." She tells of a delightful stay in Baltimore with Dr. Phoebe Way, a successful practitioner. She met and knew Emma Willard, Lucy Stone, Fredrika Bremer, Lucretia Mott, Sarah and Angeline Grimke, Antoinette Brown, and other prominent women of that period.

A most interesting chapter in this delightful journal is the one that gives the correspondence of Harriet Hunt and the authorities of Harvard. In the letter dated 1850 she writes: "The want and need for female physicians must be seen . . . There is a gap in society, a true legitimate want in our midst, to satisfy which, a separate female medical college is now struggling for life, which you may easily arrest. Unprepared, uneducated women are going forth to prescribe, urged by the necessity" . . . and the letter concludes, stating that she "in this city for fourteen years, undiplomaed and unacknowledged by the Medical Faculty, has been permitted to establish and continue herself in a new, true, elevating path for women."

Great must have been her disappointment when the class of Harvard of 1851 remonstrated against the amalgamation of sexes and races. Equally great was her joy when an honor came in the year 1853 and of this she writes: "It is in place for me here to record my thanks to the Female Medical College of Philadelphia for the honorary degree which they conferred upon me in January 1853. Courtesy and respect have led many of my patients for many years to address me as Doctor, but the recognition of that college was very pleasant after eighteen years practice. It led me to ask these questions: How many males are practicing on an honorary degree? Did they wait as many years for it?"

From the year 1850, names of women graduates appear with frequency. The majority of these women had, like men physicians, studied first with preceptors. Dr. Sarah Dolley was first taught in the office of her uncle, Dr. Hiram Corson, and Ann Preston was a pupil of Dr. Nathaniel Moseley in his private clinic where there were four women students. Elizabeth Blackwell's first knowledge of medicine was received through a preceptor, Dr. Samuel Henry Dickson of South Carolina. Esther Fussell in 1842 studied with her brother, Dr. Benjamin Fussell, and Dr. Joseph Longshore taught his sister, Hannah, and his sister-in-law. However, we know that Ann Preston and Hannah Longshore were not content with less than a fully accredited medical course, and this determination was in a large measure responsible for the founding of the Female Medical College in 1850, later our beloved Women's Medical College of Pennsylvania.

Friendships, Medicine, and Travel in Latin America

Jessie Laird Brodie, M.D.

THE THIRD CONGRESS of the Pan American Medical Women's Alliance was much more than a medical meeting. Dra. Maria Luisa Saldún, the Uruguayan vice-president of the Alliance, promised us in her invitation at the Second Congress in Los Angeles, that we should have opportunity for "much social enjoyment, as well as medical knowledge." Certainly neither was lacking. The hospitality was overwhelming. In addition, we had in the medical centers of six other countries the sight-seeing opportunities of the average tourist multiplied by personal attention from the local doctors and their friends.

December is the beginning of summer—south of the equator. For the most part it was beautiful, sunny weather. The new and magnificent 2,000-bed Hospital Clinico of Montevideo was commodious enough to house simultaneously four current medical meetings: Third Congress of the Pan American Medical Women's Alliance; Third Congress of the Pan American Pediatric Society; Third Congress of the South American Pediatric Society; and the meeting of the Uruguayan Surgical Society. One whole floor was reserved for medical exhibits and another for the commercial displays of the well-known surgical and pharmaceutical houses, familiar and friendly to doctors of both continents. The formal opening ceremony was held jointly in the medical school auditorium, and we were honored by an address of welcome by the President of the Republic of Uruguay.

At the Congress of the Pan American Medical Women's Alliance, English and Spanish resumés of all papers were available for distribution at the time of the presentation. South American doctors with postgraduate training in the United States were very generous in making impromptu translations of the discussions. This was extremely helpful in hurdling the language barrier. Socially, we all enjoyed the fun of our stumbling attempts at learning each other's languages.

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The program consisted of a very extensive covering of the medical-social problems in the various countries, as well as scientific work on recent pharmacologic and medical advances. Papers were contributed from every country represented.

Fifty women physicians from the United States registered at the Montevideo meeting. Naturally our hostess country, Uruguay, was the best represented, with over a hundred delegates; but Chile, Mexico, Brazil, and Argentina sent varying numbers of their outstanding women physicians. Bolivia, Paraguay, Peru, and Ecuador expressed regret that their low rate of exchange made impossible the sending of delegates. Knowing some of the doctors added much to local visits enroute of the tour group from the United States and Mexico. Thirty-four of us traveled as a party, with an itinerary including stopovers at six large cities. Extensive preliminary correspondence made it possible to hold miniature congresses in these places. Most delightful was the hospitality of the local physicians everywhere; primarily the women, but with much help from their male colleagues. These personal contacts wiped out distance, language barriers, and differences in medical problems. In every city, medical clinical facilities and diseases rare to us were on exhibition.

Our first stop, at San Juan, Puerto Rico, would have been very dismal, with a driving tropical rain, except for the reception committee of Puerto Rican doctors and the enjoyable supper they provided for us in the airport. The program outlined there filled every moment of our stay on the island. We were introduced in Puerto Rico to the beautiful and delicious buffet meals served by the Latin doctors. The Governor of the island ordered afternoon tea for us in the Governor's Palace, a sixteenth century fortress, La Forteleza, with a conducted tour through the historic building and exquisite tropical garden. Our farewell banquet came all too soon. We had only begun to realize what marvelous people we had found in this island territory: Dr. Alice

Scientific session at the Congress: (from left to right) Dra. Aida Lagrave de Perez Sanchez of Montevideo, chairman of the Session; Dra. Maria Luisa Saldun de Rodriguez of Montevideo, Vice-President of the Alliance and hostess for Uruguay; Dr. Cassinoni, Dean of the Medical School of Uruguay; Dr. Elizabeth Mason-Hohl of Los Angeles, California, President of the Pan American Medical Women's Alliance. The United Nations flags in the background were a gift to the Alliance from the late Dr. Donahue of U.S.A.

Reinhardt with her outstanding work at the tuberculosis sanitarium; Dr. Eloisa Muñoz, a well-trained and progressive pediatrician; Dr. A. Oliveras Guerra, president of the Puerto Rico Medical Society; and Dr. and Dra. Trelles, directors in the crippled children's work, were only a very few of those we met. We marveled at the wealth of material in their cancer hospital.

Dr. Ruth Wreszinski Tichauer of La Paz, Bolivia, hearing that the tour group would be stopping in Puerto Rico, made a hurried trip to be with us there, cutting short her vacation stay in the continental United States. We were delighted to learn that there is a very strong medical women's organization in Bolivia, known as the Bolivian Pan American Medical Women's Alliance. Her stories of Bolivian medical practices and problems fascinated us. She told of her witch doctor competitors to whom she often served morning coffee in her kitchen while exchanging with them notes on recent medical advances. Her tact and understanding of the people among whom and with whom she works, were a lesson to all of us and typical of doctors of Latin-American countries.

Our trip from Puerto Rico to Port of Spain, Trinidad, was by special chartered plane. The flight over the Lesser Antilles was beautiful, and the time seemed very short until we were circling over the tremendous asphalt lake that is the source of the main industrial wealth of the island. That flourishing English colony, with its population preponderance of African Negroes, its small colony of Hindus and Moslems, and still smaller number of English people, is a fascinating tropical fairyland. The world-famous tropical garden contains many medicinal plants in our pharmacopoeia. The guides took great delight in pointing out to the doctors each type, even to a "Lydia Pinkham Tree." The British West India radio asked for an interview, and featured our journey on a program with their famed local Calypso Singers and Bepo Band.

Three very charming women physicians met us for tea: Dr. Mary Dunn, an English physician practicing on the island; Dr. Anna Hirst, a native of Trinidad, but of English descent; and Dr. Rosie Ali, a charming Moslem doctor, beautiful in the garments typical of her people. As we had visited their hospital that afternoon, and passed many of their health clinics throughout the island, we appreciated the quality of medical service that they were giving. We were sorry that we could not have had time to meet the other six women physicians in their health units scattered throughout the island.

Our night trip by air to Rio was most comfortable. Here, too, our arrival was in the rain, which cooled the weather for our comfort, but did not cool the reception. The hospitality of the representatives of the American Embassy and the local doctors made us understand the fame of Rio. At a dinner party we made friends with the local medical people

who opened to us the doors of their hospitals and of the Institute of Inter-American Affairs.

We were amazed by the stories of Dr. Eugene Campbell and his wife, Dr. Reba, regarding the 10-year development of the work of the Health and Sanitation Division of the Institute of Inter-American Affairs. Here was the testing ground for our Point Four Program. What had been 98 percent supported by the United States, in 1942, has been taken over gradually by the Brazilian people and Government, until at the present time only 4 percent of the support of a much vaster program comes from North America. We learned how crucial, as political measures and gestures of inter-American friendship, were better sanitation, training of nurses and nurses' aides, dietary advice, DDT, and hygiene teaching. Dr. Campbell spoke of it as "Out-Communizing the Communists."

Ambassador Johnson at the American Embassy entertained us with a delightful reception where we met a large number of the American Colony.

The hospitals held much of interest in presenting unusual diseases and the historic lore of early Portuguese colonization. It gave us an opportunity to see the contrasts for which Rio is noted: an incomparable natural setting among the steep and rugged sea coast hills; extreme wealth on the one hand and most miserable poverty and illiteracy on the other.

Our destination, Montevideo, beckoned us on, all too soon. Our hostesses, the doctoras of Uruguay, crowded the airport. The air line had presented each traveler with a beautiful orchid which we in turn passed over as gifts to individual hostesses. Such an auspicious beginning continued through the week, with scientific meetings by day, and dinners, barbecues, and parties well into the night.

Remembering our enjoyment of group singing on the sight-seeing bus trip at the Second Congress in Los Angeles, we had composed a small booklet of parodies in English and Spanish and some well-known Spanish songs in both languages. At the luncheon and evening parties our colleagues from Chile and Uruguay sang with us apparently with great enjoyment. We learned later that group singing was an innovation in South America.

During the last two days we were entertained as guests of the country of Uruguay at Punta del Este, a pleasant summer resort on the Atlantic Ocean. Here the formal closing session of the Third Medical Congress was held. A 4-hour banquet followed, under the beautiful pines of the country club. Then the sunny beach and warm ocean water tempted us to swim and sun-bathe. It was hard to believe it was the ninth of December.

The strike in the airfields in Brazil interfered with the progress of our trip by air, but staterooms were found for all of us on two boats leaving Montevideo for Buenos Aires later that evening. We enjoyed the extra hours with our friends in Uruguay. Our treasured memory of this small, rich, and very hospitable country in South America will always remain with us.

We were made most welcome in Argentina. It was a shopper's heaven because of the low exchange rate and abundance of leather goods and other national products. Aside from the ever-present signs enumerating the projects of the new Argentina, and many social service developments by the Government for the poorer people, we would not have realized that we were guests in a dictatorship. The women doctors of Argentina met us for a delicious dinner at La Cabaña. Dr. Gwendolyn Shepherd, a pediatrician, was most cordial and generous with her time; her English ancestry and bilingual ability made her a capable and charming liaison for the two groups. We met also Dra. Nidia Goméz, Dra. Esther Audi, Dra. Dora Davó, Dra. Elena T. de Albino, and Dra. Telma Reca de Acosta, president of the Argentina Association of Women Doctors.

The trip across the Andes to Santiago was awe-inspiring, even to those few who suffered the effects of the altitude and the motion of the plane. The Chilean friends we had made at the Congress at Montevideo were waiting to greet us. It was like a home-coming. Flowers and fruit were in our hotel rooms, and Dra. Tegualda Ponce of Valparaiso called by long distance telephone to welcome us to Chile. Our banquet with the Santiago doctors was served on the roof of the Carrera Hotel, with its swimming pool, huasos (cowboy entertainers), and wonderful food. Dra. Paula Palaez de Alvarez helped us start the songs made famous at the Montevideo Congress. This lovely historic city charmed us all. The Virgin on Santa Lucia Hill, flooded with lights at night, was only one of the many beautiful sights we were shown during our few days there.

Valparaiso was reached by a few hours' train ride, through the rich agricultural district and then out to the sea coast. Meeting us at the station our Chilean friends from the Third Congress drove us to the Cardiologic Clinic, an outstanding example of rehabilitation of cardiac patients. There the patient is taught, in company with others, to understand his disability and to learn a new trade within his limitations. In Valparaiso the women physicians donate service and support to this center.

The Valparaiso doctoras had lunch with us at the seaside pavilion of the Hotel Viña del Mar.

Group of delegates in the corridor
Hospital Clinico, Montevideo

It was a beautiful setting, keynoted by sincere expressions of friendship and better understanding. Sight-seeing, clinic visits, a hospital tea, and a visit to the casino, were all crowded into a busy but happy day.

Throughout our stay in their country we were amazed at the large numbers of Chilean doctors, approximately three hundred, and their energy and accomplishments. Their organization, Agrupacion Medical Feminina de Chile, supports in Santiago a large polyclinic, Centro de Diagnostico Ginecologia, for the early diagnosis of cancer in women. One floor is devoted to Escuela de Educacion para el Hogar, the school of education for the home, where health teaching is directed toward bettering the hygiene of both the parents and their children. This large and astounding project the women physicians are financing and staffing entirely alone. Their vision and energy are making this worth-while achievement a success. In the front hall of the clinic is an imposing copper plaque featuring the head of Franklin Delano Roosevelt, and expressing appreciation to him and to the American people for aid in the establishment and support of this project. We were impressed in Santiago also by an outstanding woman physician, Dra. Luisa Cubillo, head of the marvelous clinical facility known as Unidad Sanitaria, a joint project of the Institute of Inter-American Affairs, and the Public Health Department of the Chilean Government. Dra. Victoria Garcia de Yazigi, director of the Unidad Sanitaria "Santa Lucia" de Santiago, is the president of the medical women's group.

As at each step of our journey, it was hard to tear ourselves away from so many charming new friends. We flew north past Aconcagua, the highest peak in the Western Hemisphere, and arrived in Lima, Peru, just after dark. For many months previous to this trip we had tried to contact by mail the group of medical women in Lima. At last a letter came from Dra. Juana Maria Solano inviting us, in the name of the women physicians of Peru, to a reception during our stay. When we arrived at the airport ten women physicians and Mrs. Barber, wife of the Minister-Consul of the American Embassy, were waiting to greet us and accompany us to the hotel. There we held an impromptu party with our new-found friends and we also found that they were just getting acquainted with each other. They had been stimulated to form their organization through our correspondence and projected visit. Nowhere in Latin America did we find better planning of hospital visits, sight-seeing, and social affairs. Their beautiful Government hospitals, their medical school, and children's and women's hospitals, were examples of good management. There we found a wealth of clinical material of great value and interest to us.

For those with anthropologic interest, our afternoon spent at the Inca ruins at Parapolis and in the valuable Lima Museum, will never be forgotten. The marvelous irrigation system that is still bring-

ing water from the Andes after 350 years, the Inca architecture and remnants of tapestries and pottery awed us all. A few could not resist dropping behind the group for a few days' trip to Cuzco, the hidden city.

Dr. Harland Paul of the Institute of Inter-American Affairs aroused our interest in the great need for his work among the Indians of the Peruvian Andes. Agriculture, sanitation, and hygiene have improved greatly through this work. Some of us had the opportunity to learn of the work of the Linguistic Institute. They are attempting to put down in written form the language of the Indian tribes. We felt we had merely scratched the surface of the many interests of the remarkable country of Peru, and all hope to have an opportunity to return for some future Pan American meetings.

We reached Panama in the middle of the night, and those from the western part of the United States with deep regret left the flight, to return to Miami. The friendships of the month's tour were very firm. Each person went her way homeward, although some were able later to make contacts with women physicians in Venezuela, Salvador, Guatemala, and Mexico.

The story of the tour and the Third Congress at Montevideo is being repeated in every city from which our fifty North Americans were drawn. We are exchanging kodachrome pictures in an attempt to complete the pictorial story that will tempt all of you to attend the next Congress. We feel we gained a wealth of medical knowledge through presentations at the Congress, as well as through clinical material in the hospitals we visited from Puerto Rico to Salvador. We have first-hand knowledge and tremendous appreciation of the splendid work being done by the organizations of women physicians, the Institute of Inter-American Affairs, the Rockefeller Foundation, the World Health Organization, the Y.M.C.A., the Linguistic Institute, and the Seventh-Day Adventist missionary projects throughout South America. We cherish the friendships we have made in all the countries we visited. These friendships should also smooth the way for Latin-American medical graduate students coming to the United States. We hope many homes will be thrown open to them while they perfect their English preparatory to entering our hospitals for graduate work. We can serve as a source of advice for obtaining scholarships and appointments for graduate studies.

We are looking forward eagerly to the opportunity of returning hospitality when the Fourth Congress meets in 1953 in the United States. We hope there will be medical women from all the countries of the Western Hemisphere present at this meeting, for through the intimacy of friendship, we acquire a greater appreciation of each other's achievements and a better understanding of each other's problems. Working together as an affiliation of national organizations we medical women can be a force toward better Pan American relations, closer international understanding, and world peace.

Women Doctors of Chile

Tegualda Ponce de Vargas, M.D.

TWO BRAVE YOUNG WOMEN, Eloiza Diaz Inzunza and Ernestina Perez Barahona, were the first Latin-American women to obtain the degree of Doctor of Medicine, and the University of Chile was the first in Latin America to bestow this degree on women. For, on February 6, 1877, during the Presidency of Anibal Pinto, the Chilean Government passed the following decree:

> *It is declared that women should be admitted to pass examinations in order to obtain a professional degree, provided they go through all the requirements to which men are submitted.*

Eloiza Diaz by special concession of the educational authorities took the last years of high school in a very exclusive school for boys, The Instituto Nacional in Santiago, and received the degree of Bachelor of Arts in 1881 when she was 15 years old. She spent the next five years in medical school at the University of Chile and for her thesis wrote "Brief Observations on the Appearance of Puberty in Chilean Women." She achieved special distinctions in obstetrics and internal medicine. When she received her medical degree in 1887 she was the first woman to achieve this distinction, not only in Chile, but in the whole of Latin America. She worked devotedly in the interests of women and children until her death November 1, 1950.

Ernestina Perez also received her Bachelor of Arts degree when she was 15 years of age, and graduated in medicine from the University of Chile shortly after Dra. Diaz. Her thesis for graduation was "Popular Medicine." She was initiated into active medical practice during the severe epidemic of cholera in Chile the same year, and her tireless and faithful work won her wide recognition. She has made many trips abroad for improving and refreshing her medical knowledge; many of these were sponsored by the Government. Dra. Perez is an honorary member of Agrupacion Medica Femenina and is still interested in the progress of medicine.

Agrupacion Medica Femenina was founded in 1938 by Government decree. It is an organization of all the women doctors of Chile with a twofold objective, the scientific education of its members and the promotion of maternal and child welfare. Its first president, Dra. Fresia Rosas de Behm, passed away in 1946. Its present officers are:

President, Dra. Victoria Garcia de Yazigi; *Secretary,* Dra. Paula Pelaez de Alvarez; *Treasurer,* Dra. Elcira Pinticart; *Directors,* Dra. Eleanira Gonzalez, Dra. Ida Thierry, Dra. Elena Ancich, Dra. Julia Imable, and Dra. Juana Diaz Munoz.

Since 1946 this organization by donations of funds and services has supported a school for the training of parents (School of Home Economics), with a program approved by the Ministry of Public Education.

In 1950 it opened the first center for cancer detection in women under the auspices of the Chilean League Against Cancer. This center is free to patients and is served voluntarily by the members of the Agrupacion. It is the headquarters of a sanitary district with a population of 70,000 inhabitants in downtown Santiago. The building used by the Agrupacion Medica Femenina belongs to Santiago's municipality, which has made this donation to encourage the Agrupacion to fulfill its objectives.

There are several local branches in provinces. The one in Valparaiso has 16 members. In the whole of Chile there are now 225 women doctors.

Dra. de Vargas is in active practice in obstetrics and gynecology in Valparaiso, Chile. Her year of specialization at the Women's Clinic of the Johns Hopkins Hospital has given her a friendly understanding of North American doctors and customs.

Opportunities for Study in the Americas

AMONG THE OPPORTUNITIES for study abroad are many which are of particular interest to women doctors of the Americas. In compiling this list of fellowships and grants, those which are limited to the nationals of one country (except the United States) or to graduates of a particular institution are not included.

Opportunities for Medical Women in Canada and Latin America

Latin-American Fellowship of the American Association of University Women is for advanced study in some educational institution of the United States. Candidates must have the equivalent of a college education and be reasonably proficient in English. Applications should be sent to the Secretary of the Committee on Fellowship Awards, A.A.U.W., 1634 Eye Street N.W., Washington 6, D.C. Stipend $1,500.

International fellowships for a year's research in a foreign country are available to all members of associations or federations of university women forming branches of the International Federation of University Women. Applications should be made to the secretary of each candidate's own national organization.

International grants are offered by the A.A.U.W. to women of other countries for study in the United States. Applications must be sent through the federation of university women in the applicant's own country, to the Secretary of the Committee on International Grants, 1634 Eye Street, N.W., Washington 6, D.C. No fixed amount is named. Applications close January 1, 1953.

The W. K. Kellogg Foundation provides approximately fifty 1-year fellowships to workers in medicine, dentistry, and related fields from Latin America and Canada for study in the United States. Application must be made through the candidate's own university.

The John and Mary R. Markle Foundation offers grants to universities in the United States and Canada for the support of qualified young scientists who wish to make a career in academic medicine. Details may be obtained from the Foundation, 14 Wall Street, New York.

The Pan American Sanitary Bureau, a regional office of WHO, offers fellowships in the field of public health to nationals of member countries. Application should be made to the Ministry of Health of the candidate's country.

Rockefeller Foundation fellowships are chiefly awarded to candidates from countries outside the United States where the Foundation has active programs. They are not awarded upon direct application, but by recommendation of the candidate's chief, and are given, in general, to members of university faculties or the staffs of research institutes or government organizations.

Research fellowship grants from the United States Public Health Service may be awarded to citizens of foreign countries. Predoctorate and postdoctorate fellowships are available; work may be done at any institution and the candidate must make all necessary arrangements for the conduct of his research. Applications must be made to the Division of Research Grants and Fellowships, U. S. Public Health Service, 19th and Constitution Ave., N.W., Washington 25, D.C.

UNICEF and WHO fellowships in public health, pediatrics, preventive medicine, basic clinical medical sciences, and so forth, are administered as noted under "Pan American Sanitary Bureau."

Quota Club International Fellowship is available to women who wish to study in the United States in such fields as will enable them to aid women and girls in their own country. The stipend is $800 to $1,000 for one year. Applications must be made to the Institute of International Education selection committees in the candidate's own country.

The Government of Argentina offers American fellowships for study in various subjects in Argentina to nationals of the American republics who are graduates of outstanding achievement in their own fields. Application should be made through the candidate's university.

Scholarships in various fields are given by the Government of Brazil to citizens of the other American republics who must have a university degree. Application is made through the Brazilian Embassy or Legation in the candidate's country.

The University of São Paulo, Brazil, has scholarships available to nationals of all countries in all branches of the university. Application must be made by August 1, each year, to Rietoria de Univerisdade de São Paulo, Rua Helvetia 55, São Paulo.

The Canadian Federation of University Women offers to women graduates of Canadian universities traveling scholarships and professional scholarships. There is no restriction on the field of study, or the country where they may be held. The Convenor of the Scholarship Committee is Dr. Doris B. Saunders, Dept. of English, University of Manitoba, Winnipeg.

McGill University has available three J. B. Collip fellowships, for nationals of all countries who hold an M.D., Ph.D., or M.Sc., for medical research at the University. The H. W. Molson Fellowship in Cancer Research is open to nationals of all coun-

tries who are graduates of a recognized medical school. Applications must be made to the Secretary, Faculty of Medicine, McGill University, Montreal.

Scholarships at the University of Chile, Santiago, are available to university students from all other Latin-American countries. Various Santiago hospitals offer staff appointments to doctors from Latin-American countries and the United States.

United States educational exchange grants, under the Convention for the Promotion of Inter-American Cultural Relations and the Smith-Mundt Act are available to nationals of other American republics. The former provide maintenance and tuition for study in the United States; the latter are designed to supplement a tuition scholarship from a U. S. university or private organization. Grants under the Foreign Lecturer and Advanced Research Scholar Program are at present available to citizens of Brazil, the Dominican Republic, Ecuador, Mexico, Peru, and Venezuela, and will probably be extended to other countries. Candidates must have high academic qualifications and be able to lecture in English. Applications for these grants should be made at the U. S. Embassy or Consulate in the candidate's country.

Altrusa International offers Inter-American grants-in-aid for study in the United States to Latin-American women. Applications may be made through the Institute of International Education selection committee in the candidate's own country, or to Mrs. Erma B. Christy, Chairman, Altrusa International Inter-American Grants-in-Aid Committee, 2820 University Ave., Muncie, Indiana.

The Coolidge Foundation gives fellowships in tropical medicine, public health, and nutrition to qualified specialists from non-Axis countries, for study in the United States in preparation for further research in Southeast Asia. Apply to Secretary, Coolidge Foundation, 70 Pine Street, New York 5.

Awards for medical research in Canada or the United States are offered to nationals of all countries who have an M.D. by the Dazian Foundation for Medical Research, 116 West 59th Street, New York 19.

A Pan American fellowship for women from Latin-American countries who wish to do graduate work in the United States is given by the General Federation of Women's Clubs. Applicants should consult the Cultural Relations Attaché at the U. S. Embassy in their country.

The Pan American Union has available to nationals of Latin-American countries free-of-interest loans for those who wish to pursue advanced studies or research in the United States, and funds for those who are already studying in the United States, or who have scholarships and need additional financial help. Apply to the Secretariat of the Leo S. Rowe Pan American Fund, Pan American Union, Washington 6, D.C.,

Graduate students from Latin-American countries who are planning to matriculate in a U. S. college or university for a full academic year are eligible for the Pan American World Airways and Braniff Airways air travel fellowships, which consist of air transportation to and from the United States. Applications must be approved by the Institute of International Education selection committee in the candidate's own country.

OPPORTUNITIES FOR MEDICAL WOMEN FROM THE UNITED STATES TO STUDY IN OTHER AMERICAN COUNTRIES

The national fellowships of the A.A.U.W.* are open to "American women who show promise of distinction for advanced study or research." The majority are unrestricted as to subject, or place of study. Detailed information may be obtained from Miss Mary H. Smith, Secretary, Committee of Fellowship Awards, 1634 Eye Street, N.W., Washington, D.C.

The Government of Mexico offers the following to U. S. citizens for study in Mexico: 1) fellowships of the Mexico-United States Cultural Co-Operative Commission, through the Institute of International Education, 1 East 67th Street, New York 21; 2) Buenos Aires Convention Fellowships available through Mexican diplomatic representatives in the United States. Similar Convention Fellowships are offered in the Dominican Republic, through its U. S. Legation.

Exchange fellowships for study in Chile may be obtained through the U. S. Office of Education, Washington, D.C.

National Research Council fellowships* in the natural sciences are offered to those having the Ph.D. or its equivalent. Apply to the Fellowship Office, National Research Council, 2101 Constitution Ave., N.W., Washington 25, D.C., by January 1, 1953. Rockefeller Foundation grants to U. S. citizens are administered through the various boards of the National Research Council.

The following awards described in Section I are available also to U. S. citizens:* International Fellowships of the International Federation of University Women; John and Mary R. Markle Foundation; American Fellowships of the Government of Argentina (apply through the Institute of International Education); scholarships of the Government of Brazil and the University of São Paulo; Collip and Molson fellowships of McGill University; Dazian Foundation; Pan American World Airways and Braniff Airways Air Travel fellowships.

M. Eugenia Geib, M.D.

*Awards marked (*) may be used in other foreign countries.

News of Women in Medicine

PAN AMERICA

Argentina. DRA. BLANCA NELLY POVOLI DE SMITH, who wrote the summary in Spanish of the article "Nutrition and the Inca," is a friend and former colleague of the author, DRA. AURORA REVILLA. Dra. Povoli obtained her training in nutrition at the Instituto Nacional de Nutricion of her native country, Argentina. She was employed in this field in Bolivia for three years. Her medical education was received in Rio de Janeiro, Brazil, and she served a year as an intern in the Sacramento County Hospital. She is now resident in pediatrics at Providence Hospital, Portland, Oregon.

Canada. The following are the officers of the Canadian Federation of Medical Women: DR. PEARL CHRISTIE-DOWLING, *President;* DR. JEAN GILLESPIE BELLAMY, *Secretary;* and DR. DOROTHY BARNHOUSE, *Treasurer.*

Mexico. Five hundred women doctors have graduated from the University of Mexico as well as from the Universities of Guadalajara and Monterrey y San Luis Patosi. The first Mexican woman doctor was MATILDE DE P. MONTOYA, who entered the University of Mexico sixty years ago.—The University of Mexico, to celebrate its 400th anniversary, inaugurated a 6-months course for nurse instructors. This is a milestone in nursing education, being the first organized college course in this subject not only in Mexico but also for all of Latin America. It was sponsored and partly financed by the World Health Organization. The faculty is outstanding and includes such women as: the consultant, SENORITA HILDA LOZIER of Chile, who has degrees in nursing from Chile and from the United States, Yale and Western Reserve Universities; SENORITA PAULA GOMEZ ALONZO, teacher of principles and techniques of teaching, one of the first pedagogists of Latin America; SENORITA PAULA ALEGRIA, sociologist and appointee many times to UNESCO; Dr. Jose H. Diaz, psychologist; and five others, all members of the different faculties of the U.N.A. of Mexico. In all, 600 hours of nursing education, psychology, sociology, and clinical supervision were included. Twenty-eight nurses, the entire number matriculating, graduated with a very significant ceremony, unusual in the history of the School of Nursing of the University of Mexico. The Latin-American tradition toward nursing, which has not been considered an entirely desirable profession for women, is being changed by such steps toward the improvement of nurses' training and its recognition by collegiate honors. SENORITA HELENA GARCIA, a graduate of the School of Nursing of the University of Yucatan, and twice a pioneer in her profession, was a recipient of a diploma in this course.

Trinidad. Of the six women doctors in active practice on the island, three are in Government service, and three in private practice. DR. ROSIE ALIE, a graduate of McGill University, Montreal, Quebec, specializes in child health in Port of Spain.

UNITED STATES

Arkansas. DR. FRANCES C. ROTHBERT is director of the Division of Maternal and Child Health of the Arkansas State Board of Health—West Memphis, Arkansas, has welcomed a highly honored woman physician of Rockport, Indiana, who has come here to retire after 63 years of relieving the suffering of humanity. She is DR. EVA BUXTON, who was 89 years of age on August 11. First a teacher, then a registered nurse who did public health nursing, she decided to study medicine at the age of 31. On June 18, 1897, she received her medical degree from Northwestern University. Dr. Buxton claimed to be nothing more than a "country doctor." Although she never married, she mothered half of Spencer County, Indiana. After completing 50 years as a physician, she was honored in 1947 by the Indiana State Medical Association. She received the 50-year pin and a certificate of merit.—LT. RUTH E. ELLIS, a graduate of the University of Arkansas School of Medicine, has been ordered overseas. She was stationed formerly at Robert Beaumont Hospital, El Paso, Texas.

California. DR. ESTHER B. CLARK of Palo Alto, California, is a member of the committee on accident prevention of the American Academy of Pediatrics.—DR. ELEANOR METHENY of the University of Southern California warns that trying to

compete physically with a 20-year-old has sent many a 50-year-old to an untimely grave. "Stay in your own league," Dr. Metheny says. "Remember that if your golf clubs are rusty with disuse, your heart and muscles are probably rusty too. So check with your doctor before starting any kind of exercise."

Georgia. Dr. Lucille J. Marsh, Atlanta, Georgia, took part in the convention of the National Rehabilitation Association, which was held in Mobile, Alabama. Dr. Marsh is medical director of the Children's Bureau, Office of Vocational Rehabilitation, in Atlanta.

Missouri. The first woman to receive her medical degree from the St. Louis University School of Medicine is Dr. Mary Frances Nawrocki. She was the only woman included in the 150 students accepted from some two thousand applicants. Dr. Nawrocki is a charter member of Gamma Pi Epsilon, woman's honor society in Jesuit schools. She is a member of the St. Louis University chapter of Alpha Omega Alpha, honorary medical society, and she is the first woman ever tapped by the fraternity at the university. Dr. Nawrocki will intern at the Philadelphia General Hospital.

Montana. Dr. Mary E. Soules, former health officer of Clackamas County, Oregon, has been appointed health officer of Missoula City, County Health Department, Montana.

New Jersey. Dr. Rita S. Finkler and Dr. Sylvia F. Becker were the recipients of an award for a scientific exhibit at the annual meeting of the Medical Society of New Jersey. The title of the exhibit was "Juvenile Endocrinopathies."—Dr. Eva T. Brodkin of Newark has been elected president of the New Jersey Dermatological Society.

New York. The Rochester Safety Council has scheduled a series of meetings on home and child safety. Two pediatricians, Dr. William H. Forsyth and Dr. Barbara A. Wood, both experts in the field of child care, are the lecturers, describing actual accident cases and outlining corrective measures with the aid of charts, graphs, slides, and motion pictures.—Dr. Ada Chree Reid, Editor of the Journal, took part in a radio program, "For the Ladies," over WNYC on July 21. She discussed "Women in Medicine."

Marcelle Bernard, M.D.

THESE WERE THE FIRST

Dr. Ellen Hammond Gladwin was the first woman to be a member of the State Medical Society of Connecticut, starting her practice of medicine in 1875 in Hartford.

Agnodice, surgeon and obstetrician in Greece and a pupil of Herophilus, is said to have been the first to use the technique of podalic version, on which she wrote a treatise. To avoid notice Agnodice wore men's clothing.

Dr. Helen Cook was the first woman graduate of the Western Homeopathic Medical College in Cleveland in 1852. This school, established in 1850, admitted women students from the beginning.

Dr. Clotilda Luisi was sent by the Government of Uruguay to be attached to its legation in Brussels, Belgium, and was the first woman so appointed. She received her doctor's degree summa cum laude at the University of Montevideo.

Dr. Marie Kjolseth was given the gold medal of the University of Christiania, Norway, in 1912 for her work in pathologic anatomy; the first time a woman had received this honor.

Mme. Dejerine-Klumpke was the first woman appointed as intern in hospitals of Paris, in 1886, and later received the Legion of Honor. She collaborated with her husband in preparing the "Anatomie des Centres Nerveux," and one type of radicular paralysis is named for her.

Dr. Marya Slodovska Curie was the first person to receive the Nobel award a second time; in 1903 the Nobel Prize in Physics was awarded half to Henri Becquerel and half to Marie and Pierre Curie as co-discoverers of radium. Upon the death of her husband she succeeded him at the Sorbonne, the first time a woman had been appointed to a position in higher education in France. In 1911 she received the Nobel Prize in Chemistry. In 1909 the degree of Doctor of Medicine was conferred upon her by the University of Geneva, in 1921 by the Women's Medical College of Pennsylvania, and in 1924 by the University of Cracow.

Dr. Jane Boyes, graduate of the University of Edinburgh in 1904, was appointed government physician for the Isle of Coll, Argyleshire, and is thought to have been the first woman physician to receive a government appointment in Scotland.

ELINOR BLACK, M.D.

DR. ELINOR BLACK'S APPOINTMENT as chairman of the Department of Obstetrics and Gynaecology at the University of Manitoba, with rank of professor, has been met with acclaim and satisfaction among her colleagues and contemporaries. Being the first Canadian medical woman to receive such an appointment is a signal honor indeed for her as well as for Manitoba.

Born in Nelson, British Columbia, Dr. Black absorbed from her Presbyterian background the high ideals and tenacity of purpose which led her to undertake and continue the study of medicine. In addition, two women doctors fired her enthusiastic resolve: Dr. Lillias Cringan-McIntyre and the late Dr. Geraldine Oakley. Incidentally, Dr. Black took a business course on the side, to provide a ready means of financial support in a field traditionally more feminine than medicine.

In 1930 she was graduated cum laude from the University of Manitoba Medical School. Postgraduate years included internship in Winnipeg and England, followed by general practice in Winnipeg for six years. During this time a preference for obstetrics and gynaecology became apparent in her work and interests. In spite of the lean years in the early thirties, her true medical interest, no doubt sustained by her Scottish Presbyterian heritage (not by bread alone) overcame the temptation to return to stenography as a more lucrative means of obtaining a comfortable living. That her motivation and labors were well justified became apparent, for in 1933 she was appointed assistant in obstetrics and gynaecology at the Winnipeg General Hospital and assistant demonstrator in obstetrics and gynaecology at the University of Manitoba. This was followed in 1937 by an appointment as lecturer in obstetrics and gynaecology at the University of Manitoba. In 1937 she prepared herself to be a Master of the Royal College of Obstetrics and Gynaecology, which title she obtained in January 1938. She spent the next six months as a resident in gynaecology at South London Hospital for Women, then returned to Canada where she practices as a certified specialist in obstetrics and gynaecology in Winnipeg.

An interesting year's leave of absence in 1948 was spent in the United States of America, the United Kingdom, and Sweden. On her return, she brought back to the staff of the Winnipeg General Hospital an instructive and fascinating account of her experiences. In this year she also was made a Fellow of the Royal College of Surgeons.

Distinctive academic honors were gained in 1950, when she was elected a Fellow of the Royal College of Obstetrics and Gynaecology, and in 1951 she was elected a Fellow of the American College of Surgeons. At her alma mater, Dr. Black progressed through the ranks with appointments in obstetrics and gynaecology, from assistant demonstrator, lecturer, assistant professor, to the final current standing of full professor and chairman of her department. In 1952 she was appointed obstetrician and gynaecologist to the Winnipeg General Hospital. She continues in her private practice in Winnipeg.

Dr. Black's life and character reveal a consistently executed and well directed effort in a medical career of such excellence that she has been accorded enthusiastically the honored position which she has earned among her colleagues. To all who know her, the personal charm and quick wit which clothe her professionalism enhance her position.

JESSIE A. MCGEACHY, M.D.

JESSIE LAIRD BRODIE, M.D.

DR. JESSIE LAIRD BRODIE, successful wife, mother, and physician, is well-known throughout the United States and the Pan American countries. In December 1951 she was chosen president-elect of the Pan American Medical Women's Alliance for 1953.

Jessie Laird was born May 5, 1898, in Detroit, Michigan. She received her A.B. at Reed College, where she majored in biology and served as a student assistant. For two years she held an experimental teaching position in grade school biology and social hygiene under the National Social Hygiene Society.

In 1921 Jessie Laird married Walter Brodie; then she turned to research and the study of medicine. With the courses required for the research she was able to enter the University of Oregon Medical School as a second year medical student in 1924. She received a Master of Arts degree in 1925, and was a member of Sigma Xi, scientific fraternity, and Alpha Epsilon Iota, medical sorority.

Dr. Jessie, as she is known, began her outstanding medical career in 1928 when she graduated from the University of Oregon Medical School. That same year she had published in the *Journal of the American Medical Association* her prize senior surgical thesis, which incorporated original research material on congenital pyloric stenosis. From that time on she has been active in many phases of the medical field. On graduation she was elected to membership in Alpha Omega Alpha, medical honorary fraternity. She interned at Multnomah County Hospital, and later was a resident in pediatrics at Doernbecher Memorial Hospital for Children. She began practice in an office in her home so that she might have close supervision of her three children while developing her practice.

Although Dr. Jessie has built up an extensive practice, she has found time to be treasurer of the Multnomah County Medical Society, chairman of the nurses' committee for the Oregon State Medical Society, chairman of the Governor's advisory board for licensing of practical nurses, chairman of the social hygiene committee of the Portland Parent-Teachers Association, and member of the Oregon State Social Hygiene Board. She also is a member of the Portland Academy of Pediatrics, county and State medical societies, and a Life member of the American Medical Women's Association. Outside of her medical affiliations, she served as an alumni regent of Reed College and is a past president of the Northwest Conference on Family Relations.

With all of Dr. Jessie's outside activity she has always had time for her family, to guide and direct her children, and to help them plan their future. Her life has been one of service, and has been an inspiration to the many young people who have come to her for guidance. She has been an outstanding example to all in the completeness of her life, in successfully co-ordinating home and profession. One is indeed fortunate to know Dr. Jessie as a friend.

HELEN A. CARY, M.D.

ALBUM OF WOMEN IN MEDICINE

MARGARITA DELGADO DE SOLIS QUIROGA, M.D.

SINCE THE FOUNDING of the Pan American Medical Women's Alliance in Mexico City, November 1947, the president, Dr. Margarita Delgado de Solis Quiroga of Mexico City, has been an active member of the group. Her prominence in the Mexican Medical Women's Association and her interest and knowledge of medical women in the other Spanish-speaking countries made her an excellent choice as second vice-president of the Pan American Medical Women's Alliance when it was founded.

On the tour to the Montevideo Congress it was a privilege for the United States delegation to travel with Dr. Delgado. When she was called upon to address the Congress it was clearly evident that she had been educated in law as well as medicine. Her training showed in her clear analysis and arbitration of problems involving both language groups.

Dr. Delgado has been the recipient of many honors, not only in her native city and country, but throughout the Americas. She graduated with highest honors from Normal School, receiving the gold medal. While attaining her medical degree she was annually awarded the first prize and silver medal. Her graduation thesis, "Study of Platelets" won the 1000 peso prize from the Faculty of Medicine of the University of Mexico.

Important positions held by Dr. Delgado during her medical career include: professor in chief of physiological and biological research of the Medical Faculty; head of biology department of Institute of Hygiene, and chief of scientific research in the Department of Health.

She was one of the founders of "Centros de Higiene y Asistencia Materno - Infantiles," and has served as acting director, assistant director, chief of visiting doctors and nurses, assistant and chief of the Medical-Social Maternal and Child Welfare Department.

As a member of the Faculty of Medicine she was the first woman to hold a chair in abnormal psychology, pedagogic psychotechnic and physiology. She is also professor of hygiene and puericulture, and psychology. For twelve years she worked with juvenile delinquents at the Women's Reformatory of the City of Mexico, and has written many papers about her observations.

The Y.W.C.A. of her country has been very fortunate in having her services as medical director and president of the Mexico City branch for ten years, as well as president of the Mexican Y.W.C.A.

Dr. Delgado is a charter member of the Mexican Society of Eugenics, charter member of the Tribuna de Mexico; member of the Mexican Association of University Women; vice-president of the Mexican Association of Puericulture; member of Association Eduardo Liceaga, Mexican Society of Biology, and Mexican Pediatrics Society; perpetual secretary of the Mexican Medical Women's Association; and at the present time a member of the Committee of Infant Protection in Mexico.

JESSIE LAIRD BRODIE, M.D.

American Medical Women's Association

PRESIDENT'S MESSAGE

The Mid-Year Board Meeting

IN CHOOSING THE TIME AND PLACE for the Mid-Year Meeting of the American Medical Women's Association, the Board of Directors considered many factors, one of the most important being geographic location. In discussing places for this year's Meeting we considered the following: In the past two years the Mid-Year Meetings have been in Asheville, North Carolina (1951), and in New Orleans (1950); the Annual Meetings of the AMWA have been in Chicago (1952), Atlantic City (1951), and will be in New York (1953). Therefore, it was decided to choose for the 1952 Mid-Year Meeting a place west of the Mississippi.

Many of our members have expressed a preference for a meeting in a place of particular interest, such as Tucson, Arizona, and Asheville, North Carolina (where we have had recent mid-year sessions), rather than in large city hotels. Accordingly, the Board has selected the Broadmoor in Colorado Springs, Colorado. Because the Clinical Session of the American Medical Association is to be held in Denver, December 2 to 5, the dates November 29 to December 1 were chosen for our Meeting in order that our members might attend both meetings if they so desired.

The Broadmoor is one of the finest hotels in the country and one where many medical meetings are held. The weather, unpredictable as weather always is, should be clear and sunny, with temperatures averaging between 50 and 60 degrees. The hotel is located in the famous Pikes Peak region of the Rocky Mountains. Since there are many sight-seeing tours through this magnificent country, some of you may wish to come early, or stay longer, in order to see as much of this section of the country as possible. There is good transportation to Colorado Springs, both by train and by air, either direct or through Denver.

REPORTS

At this Meeting each member of the Board of Directors, and this includes a delegate from each Branch, is requested to present a report of the objectives of the year and the progress made. According to the Constitution, this shall be a typewritten report in quintuplicate, double spaced, on 8½ by 11 inch plain paper, with the copies sent no later than November 10, 1952, as follows:* one to the *President,* Dr. Stenhouse; one to the *President-Elect,* Dr. Ahlem; two to the *Recording Secretary,* Dr. Wright; one to the *chairman* of the appropriate Reference Committee: Committee A—Motions and Resolutions, Dr. Schrack; Committee B—Reports of Officers, Dr. Zerfoss; Committee C—Reports of Standing and Special Committees, Dr. Phillips; Committee D—Reports of Branches and Regional Directors, Dr. Catania.

COMMITTEE MEETINGS

We hope that each Committee chairman will call a meeting of her Committee at some free time, during these days, to discuss ways and means of making the Committee function effectively. Each Regional Director should urge the state directors in her area to attend in order to learn more about the Association. Dr. Mermod, *Second Vice-President*, and *chairman* of the Committee on Membership and Organization, will be there to help.

RESERVATIONS

Make hotel reservations direct with The Broadmoor. Please send your check for the two luncheons and one dinner to Elizabeth R. Fischer, M.D., *Corresponding Secretary*, using the form on page 25.

A most cordial invitation is extended to each and every member of the American Medical Women's Association to attend this Mid-Year Meeting.

Evangeline E. Stenhouse

*The addresses of officers and committee chairmen will be found on pages 6 and 8 of this Journal.

MID-YEAR BOARD MEETING

NOVEMBER 29 TO DECEMBER 1, 1952
THE BROADMOOR, COLORADO SPRINGS
COLORADO

Saturday, November 29

Committee Meetings
9:30 a.m.—Publications Committee
2:30 p.m.—Finance Committee
8:00 p.m.—Executive Committee
7:30 to 8:30 p.m.—Reference Committees A,B,C, and D.

Sight-seeing for those who are not members of the above Committees.

Sunday, November 30

9:30 a.m.—Board Meeting
1:00 p.m.—Luncheon* — "Progress Reports."
Leader—Camille Mermod, M.D.
3:00 p.m.—Board Meeting
7:00 p.m.—Dinner*
Speaker—Carroll L. Birch, M.D., "A Year in India."

Monday, December 1

9:30 a.m.—Board Meeting
12:00 Noon—Luncheon*

Report of Council Meeting of Medical Women's International Association, Vichy, France.

1:30 p.m.—Sight-seeing

*All luncheon and dinner meetings will be held at The Broadmoor.

NEWS FROM THE BRANCHES

Branch Nineteen, Iowa

At the annual meeting of the Iowa Branch the following officers were elected: Julia Hill, M.D., *President;* Nelle S. Noble, M.D., *President-Elect;* and Jean Jongewaard, M.D., *Secretary-Treasurer.*

Branch Twenty-Six, Minnesota

The annual luncheon meeting of the Minnesota Branch was held during the Minnesota State Medical Association convention. Dr. Catherine Burns gave an illustrated and most interesting talk about her medical practice in Alaska. The following officers were elected: Nellie N. Barsness, M.D., *President*; M. Elizabeth Craig, M.D., *Vice-President*; and Catherine Burns, M.D., *Secretary.*

Letters TO THE EDITOR

Since Korea is much in the news these days, we thought perhaps you might be interested in the following items concerning foreign medical women here.

Among the first foreign medical women to return to Korea since the war are Dr. Florence Murray of Nova Scotia, Canada, and Dr. Helen Mackenzie of Victoria, Australia. They are in Seoul on the staff of the Severance Union Medical College and Hospital, an interdenominational and international institution which has lost half its plant in the war. Unfortunately, there is not, at the present time, any doctor from the United States. The medical needs in this ravaged city and devastated country are very great and more foreign staff are greatly desired.

The outpatient department was reopened in March, the inpatient department in April, and preparations are under way for reopening the medical school in the one building that remains to it. Much of the equipment was lost. There are also vacancies on the teaching staff, as some members are in national service, and others lost their lives in the war.

One of the most serious losses for both professors and medical school was that of medical books and library. Anyone wishing to help out in the replacement of these may send medical books and journals by international mail addressed to:

FLORENCE J. MURRAY, M.D., C.M.,
Pediatrics Dept., Asst. Supt.,
Severance Union Medical College Hospital,
Namtaimoon Ro, Seoul, Korea.

The Editors acknowledge with gratitude the cooperation and assistance of Dr. Jessie Laird Brodie in obtaining material for this special number of the JOURNAL.

PICTURE CREDITS

Pages 365, 366, and 367—Courtesy of Pan American Sanitary Bureau, WHO, Washington.

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EDITORIAL FORECAST
November 1952

This will be the third branch number of the JOURNAL, with articles collected under the supervision of Dr. Eleanor Scott, Guest Editor for Branch Three, Maryland.

"Induction of Labor by Rupture of the Membranes in Private Practice," by Eleanor Scott, M.D., and P. H. Harrison, Jr., M.D.

"Psychotic or Delinquent?" by Rachel K. Gundry, M.D.

"A Case of Brachial Palsy Following Gynecology Surgery," by Eleanor Scott, M.D.

"Common Feeding Problems in Children," by Mary L. Hayleck, M.D.

And a special article on the History of Branch Three by P. S. Bourdeau-Sisco, M.D., including stories of the pioneer medical women of Baltimore.

MID-YEAR BOARD MEETING

THE BROADMOOR, COLORADO SPRINGS, COLORADO

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		Please check*
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Luncheon	$3.00	_____
Dinner	4.50	_____
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Luncheon	3.00	_____
TOTAL (including gratuities)	$10.50	_____

*Please check reservations desired; make check payable to: AMERICAN MEDICAL WOMEN'S ASSOCIATION; and send to: ELIZABETH R. FISCHER, M.D., 10848 South Fairfield Avenue, Chicago 43, Ill.

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Continued on following page

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M/Sgt. Hubert L. Lee, USA Medal of Honor

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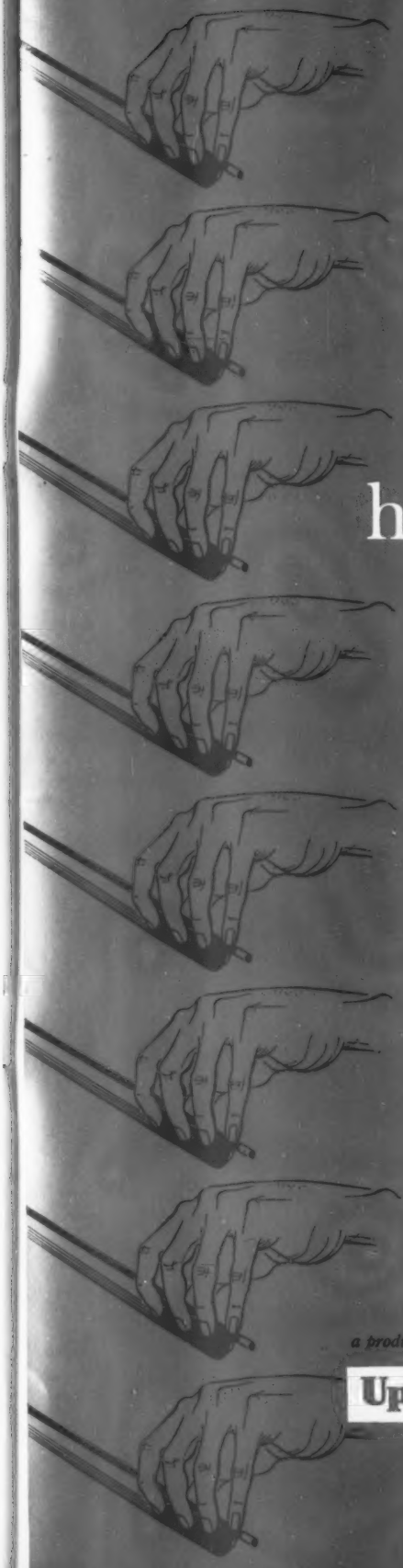

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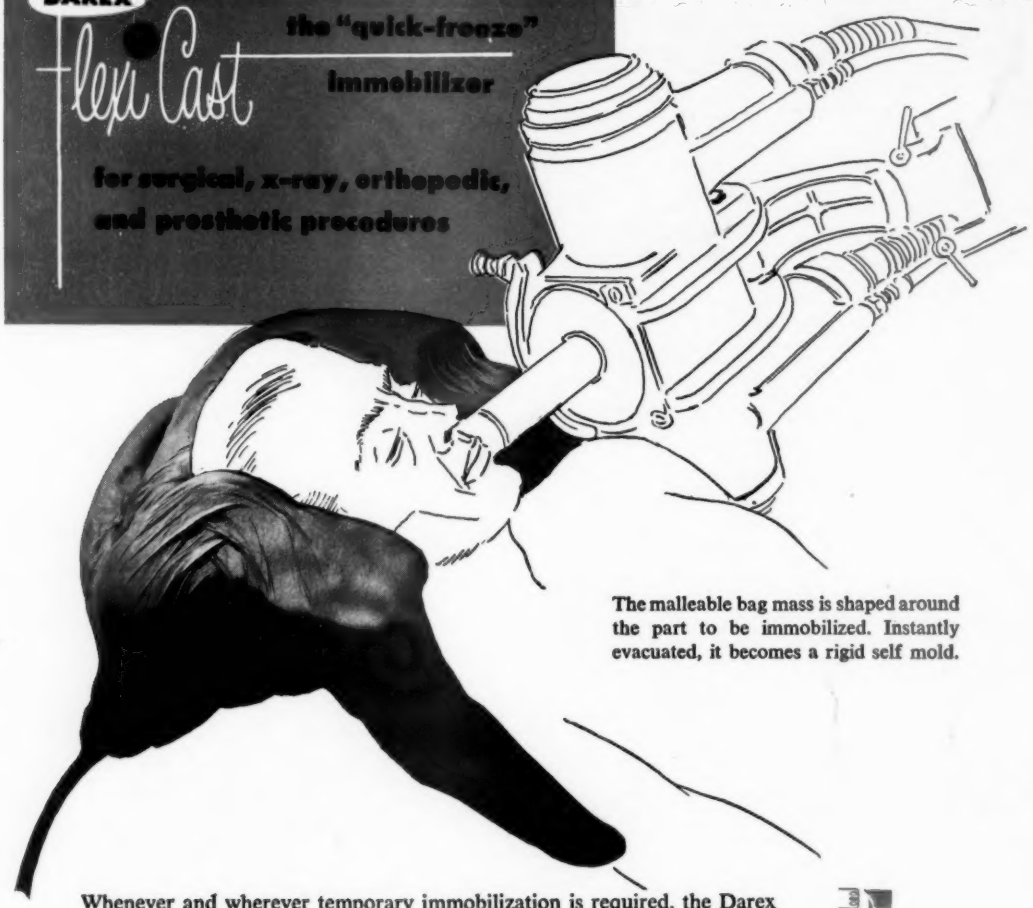

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